



# AGENCIES OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES

## REPORT ON AUDIT FOR THE YEAR ENDED JUNE 30, 2018

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## AUDIT SUMMARY

This report summarizes our fiscal year 2018 audit results for the following four agencies under the Secretary of Health and Human Resources. Collectively, these four agencies spent \$14.1 billion or 96 percent of the total expenses for agencies under this secretariat.

- *Department of Behavioral Health and Developmental Services*
- *Department of Health*
- *Department of Medical Assistance Services*
- *Department of Social Services*

Our audits of these agencies arise from our work on the Commonwealth's Comprehensive Annual Financial Report and Statewide Single Audit of federal funds. Overall, we found the following:

- proper recording and reporting of all transactions, in all material respects, in the Commonwealth's accounting and financial reporting system, each agency's accounting records, and other financial information reported to the Department of Accounts;
- forty-seven findings involving internal control and its operation, necessary to bring to management's attention. Of these findings, two are considered to be material weaknesses;
- thirty-six out of the forty-seven findings are also considered to be instances of non-compliance with applicable laws and regulations that are required to be reported; in addition, there is one instance of non-compliance that does not involve internal control and its operation; and
- eleven out of the forty-eight findings are matters not adequately resolved from the previous year that are repeated in this report. Two of these are partial repeats meaning that some progress had been made since our previous report.

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## INTERNAL CONTROL AND COMPLIANCE FINDINGS AND RECOMMENDATIONS

This section is organized by agency and each finding reported includes information on the type of finding and the severity classification for the finding. The severity classifications are discussed in more detail in the section titled “Independent Auditor’s Report.” In addition, those findings that report on issues that were not resolved from our previous audit and are repeated in this report are also designated.

### DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

#### Why the APA Audits Contractual Commitments

The Department of Behavioral Health and Developmental Services (DBHDS) has contractual commitments that are material to the Commonwealth’s Comprehensive Annual Financial Report (CAFR). Incorrect reporting of contractual commitments could cause a material misstatement in the CAFR disclosures. We reviewed the contractual commitments disclosure submitted by DBHDS to the Department of Accounts (Accounts) during the fiscal year to determine whether commitments were accurate and properly reported.

#### **Improve Controls over Financial Reporting**

**Type:** Internal Control

**Severity:** Significant Deficiency

**Repeat:** No

DBHDS did not accurately report contractual commitment amounts to Accounts for inclusion in the Commonwealth’s CAFR. As a result, DBHDS understated other contractual commitments by approximately \$19.5 million and overstated construction contractual commitments by approximately \$3.9 million. Additionally, DBHDS lacks policies and procedures over the compiling of commitments.

Accounts Comptroller’s Directive No. 1-18 establishes compliance guidelines and addresses financial reporting requirements for state agencies to provide information to Accounts for the preparation of the CAFR as required by the Code of Virginia. Accounts requires state agencies to submit information as prescribed in the Comptroller’s Directives and individuals preparing and reviewing the submissions are required to certify the accuracy of the information provided to Accounts.

For fiscal year 2018, the Office of Budget Execution and Financial Reporting (Budget Execution) employed a new estimation process to determine other contractual commitment amounts. Using a list of active contracts, Budget Execution prorated the contract amount over the remaining life of the contract, which is a reasonable estimation process. The contract list, provided by Procurement and Administrative Services (Procurement), included both term and fixed price contracts; however, the relationship between the contract amount and term was not always clear. Budget Execution did not communicate with Procurement to verify its understanding of the contract amounts and terms provided before applying the estimation process, resulting in an overstatement of \$19.5 million.

For construction contracts, Budget Execution calculated commitments using DBHDS' new in-house capital project management system based on the contract value less payments through fiscal year end. However, the in-house capital project management system only included payment data for fiscal year 2018. Budget Execution did not validate that the payments in the project management system included all life to date expenses, since the contract began in fiscal year 2014, resulting in an overstatement of commitments of \$4.1 million. In addition, Budget Execution did not include change order amounts as part of the contract value for another contract, resulting in an understatement of \$206,103.

Budget Execution should develop and implement policies and procedures for compiling other contractual and construction contractual commitments. Management should ensure the procedures provide personnel sufficient guidance on the purpose and importance of the information requested and direction regarding the support needed to prepare the submission, as well as adequate controls to prevent or detect and correct mistakes. In addition, Budget Execution should ensure they have a complete understanding of any data used in calculating commitments.

#### Why the APA Audits Information Systems Security

DBHDS collects, manages, and stores significant volumes of personal and financial data within its mission critical systems. Because of the highly sensitive and critical nature of this data, DBHDS management must take all necessary precautions to ensure the integrity and security of the data within its systems. To determine if information technology governance, database security, oversight of sensitive systems, and contingency management were adequate, we compared the practices of DBHDS to those required by the Commonwealth's Information Security Standard (Security Standard), SEC 501.

#### **Improve IT Contingency Management Program**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2017)

DBHDS does not have complete and current Continuity of Operations Plans (COOP) and Information Technology (IT) Disaster Recovery Plans (DRP) for the facilities and Central Office. DBHDS assigned resources and submitted work requests to the Virginia Information Technologies Agency (VITA) to address the lack of current and complete COOPs and DRPs. However, due to the transition of the Commonwealth's Partnership with Northrop Grumman to the new managed services with Science Applications International Corporation (SAIC), VITA is unable to provide some of the information necessary for DBHDS to complete the COOPs and DRPs. DBHDS plans to work with SAIC and VITA to obtain cost estimates and develop a plan to address disaster recovery and continuity of operations.

DBHDS has hospitals, mental health institutes, and training centers that manage their own mission critical IT applications that help provide patient services. Three of these facilities do not have a

COOP, one facility and the Central office do not have a DRP, and the remaining facilities' COOPs and DRPs are out-of-date, with some as old as 2009. In addition, the Central Office and the facilities are not performing annual tests on the COOPs or DRPs.

The Security Standard, Section CP-1, requires DBHDS to develop and disseminate procedures to facilitate the implementation of a contingency planning policy and associated contingency planning controls. The Security Standard also requires the agency to maintain current COOPs and DRPs and conduct annual tests against the documents to assess their adequacy and effectiveness.

By not having current COOPs and DRPs, DBHDS increases the risk of mission critical systems being unavailable to support patient services. In addition, by not performing annual tests against the COOPs and DRPs, DBHDS is unable to identify weaknesses in the plans and may unnecessarily delay the availability of sensitive systems in the event of a disaster or outage.

DBHDS should continue to work with VITA and SAIC to remediate the weaknesses in the continuity of operations and disaster recovery processes and ensure the contingency management program meets the minimum requirements in the Security Standard. DBHDS should develop and update the COOPs and DRPs ensuring they are consistent across the facilities and Central Office. DBHDS should also perform annual tests against the COOP and DRP to ensure Central Office and the facilities can restore mission critical and sensitive systems in a timely manner in the event of an outage or disaster. Doing this will help to ensure DBHDS maintains the confidentiality, integrity, and availability of their mission critical and sensitive systems.

#### **Continue to Upgrade Unsupported Technology**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2015)

DBHDS is not protecting sensitive data by using end-of-life or end-of-support technologies for sensitive systems. However, DBHDS is making significant progress in upgrading, consolidating, and decommissioning the end-of-life systems that contain Health Insurance Portability and Accountability Act (HIPAA) data, mission-critical financial data, and Personal Health Information (PHI) data. DBHDS made this a priority over the past two years and hired three external developers, an external business analyst, and dedicated internal resources to remediate the end-of-life technology. Due to limitations of its legacy systems, DBHDS continues to operate technology that the vendor no longer supports.

DBHDS is planning to replace each legacy application during 2019. In the meantime, DBHDS submitted security exceptions to VITA to continue using the end-of-life technology until the agency can decommission and replace it with current technology. However, VITA's Chief Information Security Officer has not yet approved the exceptions.

The Security Standard, Section SI-2-COV (c), requires that organizations prohibit the use of products designated as end-of-life or end-of-support by the vendor or publisher. By using end-of-life or end-of-support technology, DBHDS can no longer receive and apply security patches for known

vulnerabilities, which increases the risk that a malicious attacker may exploit these vulnerabilities leading to a data breach. DBHDS has systems using end-of-life technology that contain HIPAA data, and if a data breach occurs, it can result in large monetary penalties, up to \$1.5 million. Additionally, vendors do not offer operational and technical support for end-of-life and end-of-support technologies, which effects data availability by increasing the difficulty of restoring system functionality if a technical failure occurs.

DBHDS has a decentralized IT department and, in the past, lacked the proper governance to maintain their sensitive systems and meet the minimum requirements in the Security Standard. This caused DBHDS to have legacy applications that run on end-of-life software versions, and DBHDS cannot upgrade them to newer technology without disrupting the application.

DBHDS has improved the governance over the information security program and has plans to remediate the remaining end-of-life and end-of-support technologies. DBHDS should work with VITA to receive approval for the security exceptions they submitted. In addition, DBHDS should continue to prioritize the upgrade, consolidation, or decommission of all end-of-life and end-of-support technologies. Doing this will reduce the risk to the confidentiality, integrity, and availability of sensitive Commonwealth data.

#### **Develop Baseline Configurations for Information Systems**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2015)

DBHDS does not have documented baseline configurations for their sensitive systems' hardware and software requirements. DBHDS is working to reduce the total number of sensitive systems, but still has 171 sensitive systems, with some containing HIPAA data, social security numbers, and PHI data. DBHDS is in the process of implementing software that has the ability to establish, configure, and monitor baseline configurations. The IT security analyst responsible for testing the software product and implementing it into the production environment left DBHDS in September 2018. The agency assigned the work effort to another IT security analyst and plans to complete the implementation in 2019.

The Security Standard, Section 8 Configuration Management, CM-2 and CM-2-COV, requires DBHDS to perform the following:

- Develop, document, and maintain a current baseline configuration for information systems. (CM-2)
- Review and update the baseline configurations on an annual basis, when required due to environmental changes, and during information system component installations and upgrades. (CM-2)

- Maintain a baseline configuration for information system development and test environments that is managed separately from the operational baseline configuration. (CM-2)
- Apply more restrictive security configurations for sensitive systems, specifically systems containing HIPAA data. (CM-2-COV)
- Modify individual IT system configurations or baseline security configuration standards, as appropriate, to improve their effectiveness based on the results of vulnerability scanning. (CM-2-COV)

The absence of baseline configurations increases the risk that these systems will not meet the minimum security requirements to protect data from malicious access attempts. Baseline security configurations are essential controls in information technology environments to ensure that systems have appropriate configurations and serve as a basis for implementing or changing existing information systems. If a data breach occurs to a system containing HIPAA data, the agency can incur large penalties, up to \$1.5 million.

DBHDS should assign an IT security analyst, develop a plan, and prioritize the installation of the software to establish and maintain security baseline configurations for their sensitive information systems to meet the requirements in the Security Standard. Doing this will help ensure the confidentiality, integrity, and availability of the agency's sensitive data.

### **Improve Application Security**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

DBHDS is not meeting some of the minimum requirements in the Security Standard for a sensitive application. DBHDS uses the application for wage employees, such as nurses and clinical staff, at the agency's fourteen facilities. The application is the originating system for wage employee hours and interfaces with the Commonwealth's payroll system. During fiscal year 2018, DBHDS had wage payroll totaling over \$12 million making the integrity and availability of the application critical to the agency. The following weaknesses exist for the application:

- DBHDS only has one central administrator that manages and maintains the application. Each facility has an administrator to handle small issues at their facility; however, the one central administrator at the Central Office is the only one responsible for tasks such as reviewing audit reports, setting up and configuring pay rules, granting and modifying administrator access for the facilities, and monitoring system performance. The Security Standard, Section AC-2-COV, requires DBHDS to have at least two individuals with administrator accounts to each IT system to provide continuity of operations. By having one administrator, DBHDS increases the risk of



disruptions to the wage payroll process at the facilities if the administrator leaves the agency.

- DBHDS does not have procedures to support the day-to-day operations of the application. Since there is only one central administrator, the lack of procedures increases the risk of potential disruptions to the wage payroll process at the fourteen facilities. Specifically DBHDS lacks procedures for the application in the following areas:
  - **Procedures to support the baseline software configuration** – The Security Standard, Section CM-2-COV, requires DBHDS to identify, document, and apply more restrictive security configurations for sensitive IT systems. If the application has an outage and DBHDS needs to reestablish the application, the baseline software configuration and procedures will provide the minimum software requirements to reconstruct the system. The documentation will include items such as specific settings and configurations for DBHDS' instance of the application, minimum version and patch levels, and the specific installation guide to use. By not having this documentation and procedures, DBHDS increases the risk they will not recover the application timely and cause disruptions to the wage payroll process for the fourteen facilities.
  - **Procedures to facilitate system events monitoring** – The Security Standard, Section AU-1, requires DBHDS to develop procedures to facilitate the implementation of the audit and accountability policy and associated controls. The central administrator currently runs multiple audit reports and monitors system performance for the application, but there are not any procedures for the process. Not having procedures for monitoring system events could cause disruptions to the availability of the application if the administrator is unavailable.
  - **Procedures to manage access control and account management** – The Security Standard, Section AC-1, requires DBHDS to implement procedures to facilitate the implementation of the access control policy and associated access controls. In addition, the Security Standard, Section AC-2, requires DBHDS to implement various account management processes such as establishing groups and role membership, and creating, modifying, and removing accounts in accordance with the agency's access control policy. By not having procedures that detail the access control and account management processes for the application, the agency could experience disruptions if the administrator is unavailable.
- DBHDS did not update the Risk Assessment after the application went through a recent upgrade to the software and servers. The Security Standard, Section RA-3, requires DBHDS to update the risk assessment on an annual basis or whenever there are significant changes to the information system or environment. Without completing new risk assessments when a system undergoes a significant modification,

DBHDS may not identify risks to the system and implement the necessary mitigating controls.

The primary contributing factor to these security weaknesses is the lack of resources dedicated to administer the application. The central administrator is aware of the necessity to develop and document procedures for continuity of operations; however, the administrator's current workload makes it difficult to support the application and develop and document procedures. The IT security group is working on updating the risk assessment and expects to complete it by December 2018.

DBHDS should hire or assign an individual to be a backup to the central administrator. The agency should also dedicate the necessary resources to develop and document procedures to support the application. In addition, DBHDS should update the risk assessment to ensure sufficient mitigating controls are in place. Doing this will help to ensure DBHDS maintains the confidentiality, integrity, and availability of their mission critical and sensitive systems.

#### **Improve Access Controls over the Internal Accounting System**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

DBHDS does not have current written policies and procedures over access to its internal accounting and financial reporting system. The most recent policies and procedures, which are from 2006, are outdated and do not reflect changes that were implemented during the system upgrades that occurred during 2011 and 2015. Further, DBHDS did not follow their formal, internal processes to monitor access periodically to the internal accounting and financial reporting system for all regions and facilities. Specifically, we found the following issues with user access to the internal accounting and financial reporting system:

- Eight out of 25 (32%) users tested had access that was not properly approved by the employee's supervisor or approving officer prior to the access effective date.
- Four out of 25 (16%) users tested had access to the internal accounting and financial reporting system that did not agree with the access level on the user access form. Two of those users no longer needed that access level and had access that was not consistent with their job duties.
- One out of three (33%) terminated users tested had access that was not removed within 24 business hours. Removal for this user took over 21 days.

Throughout the year, monitoring activities over user access to the internal accounting and financial reporting system occurred only at a few regions and facilities. Monitoring did not include a review of all critical user access roles and users who may have terminated during the year. Additionally, personnel from the Information Security Office performed monitoring activities over user access once

we requested user listings from the internal accounting and financial reporting system, confusing and delaying the audit process.

The Security Standard, Section AC-2-COV 2e and f, requires notification of terminations, transfers of employees, and contractors and prompt removal of access when no longer needed. Security Standard, Section AC-6, requires granting access based on the principle of least privilege and only authorizing user access, which is necessary to accomplish tasks in accordance with organizational missions and business functions. Furthermore, Part 7 of Section AC-6 requires the performance of an annual review of access to validate that the need for such access still exists.

Not ensuring that system users have and retain appropriate access to the internal accounting and financial reporting system increases the risk of unauthorized individuals inappropriately entering or approving transactions and could affect the integrity of DBHDS transactions in the internal and Commonwealth's accounting and financial reporting systems. Due to an increased workload from the upgrade of the internal accounting system and the implementation of the Commonwealth's new accounting and financial reporting system in 2016, personnel did not update internal policies and procedures over the internal accounting and financial reporting system. When upgrading the internal accounting system, DBHDS migrated all user access to the new version, but did not create the new access forms until after conversion. Personnel in the Information Security Office did not understand the purpose and timing of when to perform monitoring activities, incorrectly assuming it was part of the audit process. In addition, DBHDS has not provided proper training to its facility managers and regional security administrators on how to assign, change, and remove user access.

Management should establish and implement proper policies, procedures, and controls over access to the internal accounting and financial reporting system. Management should ensure that monitoring activities take place over all critical user access at all regions and facilities. Management should ensure that monitoring of access to the internal accounting and financial reporting system does not occur during the external audit process. Furthermore, management should provide proper training to facility managers and regional security administrators.

#### **Develop and Implement Compliant Application Access Management Procedures**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

The 14 facilities within DBHDS have application access management procedures that do not meet the requirements in the DBHDS Account Management Policy. The DBHDS Information Security Office issued the Account Management Policy to provide the facilities with a baseline of minimum requirements to help ensure compliance with the Security Standard. Access management procedures that meet the minimum requirements in the Security Standard are critical to protect the facilities sensitive systems that contain HIPAA data, social security numbers, and PHI data. As a result, none of the facilities' access management procedures comply with the Security Standard in regards to access management. In addition, we found several issues with access to the internal accounting system as noted in the finding, "Improve Access Controls over the Internal Accounting System."

Security Standard, Section AC-1, requires an organization to develop, document, and disseminate procedures to facilitate the implementation of the access control policy and associated access controls. For DBHDS, the system owners at the facilities are responsible for developing application access management procedures that align with the requirements in the Account Management Policy. Not having adequate access control policies and procedures increases the risk that individuals will have inappropriate access and can potentially process unauthorized transactions.

The system owners at each facility should engage the Information Security Office to create application access management procedures. The Information Security Office should work with the individual facilities to set reasonable deadlines and monitor their progress to ensure their application access management procedures meet the minimum requirements in the Account Management Policy and the Security Standard.

#### **Why the APA Audits Capital Asset Management**

DBHDS has 14 individual locations throughout the Commonwealth. DBHDS owns over \$632 million in capital assets, including the purchase of over \$5 million of capital assets during the fiscal year. Because of the large number of capital assets associated with multiple locations, DBHDS management must implement appropriate controls to account for and manage all capital assets properly. During the fiscal year, DBHDS sold the Northern Virginia Training Center (NVTC) and as part of its plan to comply with the Department of Justice settlement, DBHDS plans to close one more facility by the end of fiscal year 2020. We reviewed DBHDS' corrective action plan to the prior-year audit finding and compared the practices of DBHDS to those required by the Commonwealth Accounting Policies and Procedures (CAPP) Manual.

#### **Improve Internal Controls over Capital Assets**

**Type:** Internal Control

**Severity:** Deficiency

**Repeat:** No

DBHDS sold the NVTC property to a private party in November 2017. As of December 2018, DBHDS has not removed the NVTC land, buildings, and infrastructure assets valued at over \$17 million from the Commonwealth's fixed asset system. Not removing asset values for land sales resulted in an overstatement of assets in the Commonwealth's fixed asset system. Because the Fiscal Services Department (Fiscal Services) staff did not have access to the NVTC assets in the fixed asset system, they began working with Accounts to remove the assets in March 2018. However, Fiscal Services staff did not follow through and ensure that the transactions were complete, resulting in the assets remaining in the system.

CAPP Manual Topic 30805 states that it is important for assets that are no longer under the control of the agency to be disposed of in the Commonwealth's fixed asset system to ensure that financial statements containing capital asset information, such as the Commonwealth's CAFR, are

accurate. Disposals should be recorded in the Commonwealth's fixed asset system during the fiscal year in which the change in asset status occurred.

Fiscal Services should ensure that they remove sold and disposed assets timely. When closing facilities in the future, Fiscal Services should consider obtaining access to the financial records of the facility in all of the Commonwealth's systems so that they can handle final transactions timely.

#### Why the APA Audits the Individual DBHDS Facilities

DBHDS is decentralized in nature and operates 14 facilities throughout the Commonwealth. Since each facility has their own processes and procedures, we performed testwork over expenditure and journal entry transactions, financial system reconciliations, retirement benefits, and employment eligibility at the individual facilities on a cyclical basis. During fiscal year 2018, we tested the following facilities:

- Central State Hospital
- Commonwealth Center for Children and Adolescents
- Northern Virginia Mental Health Institute
- Southern Virginia Mental Health Institute
- Western State Hospital

#### Improve Controls over the Purchasing Process

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

One out of five facilities tested did not have proper controls in place over the purchasing process during fiscal year 2018. For five of 20 (25%) expenditures tested, Fiscal Services did not accurately record the goods or services receipt date in the Commonwealth's accounting and financial reporting system. Fiscal Services misunderstood the requirements for the good or services receipt date, using the invoice date or payment certification date instead of the date the goods or services were physically received.

The Procurement Department (Procurement) did not enter and receive confirming orders for six of 20 (30%) expenditures tested, which were for prescription drug and medical expenditures. Due to changes in procurement regulations, Procurement did not properly process these expenditures through the Commonwealth's purchasing system, as required, which is where approval usually occurs. However, management did ensure that they properly approved purchase requisitions for the prescription drug and medical expenditures.

The goods or services receipt date is a required field in the Commonwealth's accounting and financial reporting system. The good or services receipt date affects payment due dates and year-end payable accruals; therefore, it is essential that agencies accurately record the good or services receipt date.

Section 14.9 of the Agency Procurement and Surplus Property Manual requires the use of the Commonwealth's purchasing system for certain purchase transaction types. Procurement Information Memoranda 98-034 that became effective July 1, 2017, requires the use of the Commonwealth's purchasing system for purchases made under the Division of Purchases and Supply authorized multi-state drug contract. Without processing certain purchases through the Commonwealth's purchasing system, there is an increased potential for reduced transaction transparency, analysis, and reporting.

Management should ensure that the appropriate personnel in Fiscal Services understand and accurately record the good or services receipt date in the Commonwealth's accounting and financial reporting system. Management should ensure that personnel in Procurement remain well informed and knowledgeable on the latest updates to the procurement regulations. Furthermore, management should properly review and approve purchase orders.

#### **Why the APA Audits an Agency's Controls Over their Information in the Commonwealth's Retirement Benefits System**

The Commonwealth's retirement benefits system is used to calculate the total pension liabilities for the Commonwealth. Individual agencies are responsible for updating the records within the retirement benefits system related to their employees. As a result, DBHDS management must take adequate precautions to ensure the integrity of these records. To determine if management implemented these precautions, we compared the individual facilities practices to the guidance provided by Accounts and the Virginia Retirement System (VRS).

#### **Improve Controls over the Commonwealth's Retirement Benefits System**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2014)

Individual facilities within DBHDS did not have adequate controls in place during fiscal year 2018 to ensure that retirement information for employees was accurate, specifically:

- One of five facilities tested (20%) did not perform a complete reconciliation of the credible compensation between the Commonwealth's human resource and retirement benefits systems.
- Three of five facilities tested (60%) did not have documented evidence of a reconciliation of the credible compensation between the Commonwealth's human resource and retirement benefits systems. As a result, these facilities did not perform a complete reconciliation prior to confirming the contribution.

- One of five facilities tested (20%) did not clear exceptions identified on the Commonwealth's human resource system cancelled records reports in a timely manner.
- Four of five facilities tested (80%) did not clear exceptions between the Commonwealth's payroll and retirement benefits systems in a timely manner, as identified on the Commonwealth's payroll system automated reconciliation reports.
- Two of twenty-one (10%) former Commonwealth retirement benefits system users tested at two facilities did not have their access removed timely (within 24 business hours). Removal for one user took over a year, and the other user still had access to the Commonwealth retirement benefits system as of June 2018.

CAPP Manual Topic 50410 states that agencies should perform a reconciliation of credible compensation between the Commonwealth's human resource and retirement benefits systems monthly before confirming the contribution. Further, CAPP Manual Topic 50410 requires agencies to promptly clear exception items identified on the Commonwealth's payroll system automated reconciliation reports. Improper reconciliation processes can affect the integrity of the information in the Commonwealth's retirement benefits system that determines pension liability calculations for the entire Commonwealth. Since the VRS actuary uses retirement benefits system data to calculate the Commonwealth's pension liabilities, inaccurate data could result in a misstatement in the Commonwealth's financial statements.

The Security Standard, Section AC-2, addresses requirements over account management practices for requesting, granting, administering, and terminating accounts. Specifically, it requires agencies to disable unneeded accounts in a timely manner. Delays in deleting access increases the risk of unauthorized use of the Commonwealth's retirement benefits system by terminated employees, which could result in unauthorized changes and could impair data integrity.

Individual facilities staff were unsure of how to perform several components of the reconciliation process; therefore, they did not perform pieces of the reconciliation process during the fiscal year. Due to turnover, facilities staff did not retain documentation that reconciliation to the Commonwealth's retirement benefits system occurred. Additionally, due to the lack of understanding of documentation requirements, facilities staff did not maintain documentation showing the clearing of exceptions from the Commonwealth's human resource system cancelled records reports and Commonwealth's payroll system automated reconciliation reports.

Management should ensure that individual facility staff are aware of monthly reconciliation requirements outlined within CAPP Manual Topic 50410 and that facility staff perform monthly reconciliations between the Commonwealth's human resource and retirement benefits systems. Facility staff should clear exceptions noted in the Commonwealth's human resource system cancelled records and the Commonwealth's payroll system automated reconciliation reports timely. In addition, facility staff should document and maintain supporting documentation evidencing the clearing of exceptions.



Management should remove unneeded access to the Commonwealth's retirement benefits system in a timely manner, in accordance with the Security Standard.

#### Why the APA Audits Compliance with Employment Eligibility Guidelines

DBHDS employs over 6,000 employees, hiring a significant number each year. Noncompliance with Federal government employment eligibility guidelines could result in financial penalties. To determine compliance with the employment eligibility process, we reviewed the individual facilities processes and forms used to verify both employment eligibility and identity. We compared their processes to those required by the Federal government and the Code of Virginia.

#### Comply with Employment Eligibility Requirements

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Individual facilities within DBHDS do not have sufficient processes and controls over the employment eligibility process. Human Resources Departments (Human Resources) at the facilities are not completing the Employment Eligibility Verification forms (Form I-9) in accordance with guidelines issued by the U.S. Citizenship and Immigration Services of the Department of Homeland Security. Additionally, Human Resources did not comply with E-Verify program requirements outlined within the Code of Virginia. During fiscal year 2018, we noted the following:

- Human Resources could not locate Form I-9 and E-Verify documentation for two out of 51 (4%) employees tested.
- Human Resources did not authorize seven out of 51 (14%) employees tested in the E-Verify system.
- Human Resources used an expired Form I-9 for one out of 51 (2%) employees tested.
- Fourteen of 51 (27%) employees tested did not sign Section 1 of the Form I-9 on or before the first date of employment.
- Three out of five (60%) facilities tested did not have written policies and procedures over employment eligibility.

The Immigration Reform and Control Act of 1986, requires that all employees hired after November 6, 1986, have a Form I-9 completed to verify both employment eligibility and identity. The U.S. Citizenship and Immigration Services sets forth federal requirements for completing the Form I-9 in the Handbook for Employers M-274. The Code of Virginia (§40.1-11.2) requires newly hired employees of all Commonwealth agencies to be enrolled in the E-Verify program. Not complying with federal and



state statutes could result in substantial civil and/or criminal penalties and debarment from government contracts.

The issues listed above occurred because Human Resource employees at the facilities have not received proper training in this area. Management should provide adequate training to Human Resources staff on the proper completion of the Form I-9 and ensure that forms are properly completed and retained in accordance with U.S. Department of Homeland Security guidelines. Additionally, management should ensure that there are written policies and procedures over employment eligibility.

#### Why the APA Works with DBHDS Internal Audit to Audit Payroll

DBHDS employs over 6,000 salaried and wage employees across central office and 14 facilities. DBHDS' payroll expenditures exceeded \$440 million during the fiscal year. Because of the sizeable nature of this expense to the Commonwealth, DBHDS management must implement adequate controls to ensure the integrity of payments to employees. To determine if controls over payroll were adequate, DBHDS Internal Audit compared the practices of DBHDS to those required by the CAPP Manual. DBHDS Internal Audit tested payroll at the following individual facilities during the fiscal year:

- Catawba Hospital
- Central Virginia Training Center
- Eastern State Hospital
- Southern Virginia Mental Health Institute

#### Improve Controls over Payroll

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2014)

Individual facilities within DBHDS do not have adequate controls in place to ensure pay changes are approved, payroll is appropriate, and access is removed timely. Specifically:

- Six out of 23 (26%) former Commonwealth's human resource system users tested did not have their access removed timely. Removal of access for these users took between one to 36 weeks after employee separation.
- Seven out of 12 (58%) Commonwealth's payroll to human resource systems exception reports tested did not contain documented evidence of proper review and approval.
- One of 27 (4%) DBHDS' time, attendance and leave system users tested had an access level provided by the facility that did not match their approved access form; however, the access was appropriate for the employee's job duties.

- Five of 80 (6%) employees tested in regular payroll and one out of 17 (6%) employees tested in pay changes had instances where the Payroll Department did not receive complete authorizing documentation containing required management signatures for all types of changes in pay.

CAPP Manual Topic 50505 states that agencies must verify that all source documents such as timecards, timesheets, or any other authorization used to pay or adjust an employee's pay have been properly completed, authorized by the appropriate party, and entered accurately into the Commonwealth's payroll system.

The Security Standard, Section AC-2-COV 2 e and f, requires the prompt removal of system access for terminated or transferred employees. The Security Standard, Section AC-2-COV 2 a, requires granting access to the system based on a valid access authorization. The Security Standard, Section AC-6, requires agencies to employ the principle of least privilege allowing only authorized access for users, which are necessary to accomplish assigned tasks in accordance with organizational missions and business functions.

Not having properly approved and authorized payroll forms increases the risk that DBHDS could pay unauthorized and/or incorrect salaries. Not removing access of terminated employees timely or having an employee with unapproved access increases the risk of unauthorized individuals inappropriately entering or approving transactions. Furthermore, it could compromise sensitive employee information. The lack of proper review of the Commonwealth's payroll to human resource systems exception reports and approval of changes made to clear exceptions could result in erroneous payments being made or payments that exceed classification limits.

These exceptions occurred because the individual facilities either did not have adequate policies and procedures for payroll forms or did not comply with established CAPP Manual guidance or internal policies and procedures for payroll forms. Additionally, the exceptions resulted from a lack of communication and understanding between personnel in the Human Resources and Payroll Departments.

Management across all DBHDS facilities, not just those tested, should evaluate and update policies and procedures to provide adequate guidance to ensure proper approval and completion of payroll forms and pay changes. Management should ensure that there is adequate communication between personnel in the Human Resources and Payroll Departments. In addition, Human Resource and Payroll Department personnel should ensure that they receive properly approved and completed payroll forms before processing pay changes. Management for all facilities should also remove all access, in a timely manner, for employees that terminated, resigned, or no longer need access. Lastly, management for all facilities should remove all access levels that do not match the employees' approved access form, or update the form if the level of access is necessary for the employees' job function.

### Why the APA Audits Hours Worked by Wage Employees

DBHDS employs a significant number of wage employees who are not eligible to participate in the state health insurance plan. Because of the financial penalties associated with violating Federal laws pertaining to health insurance coverage, DBHDS management must implement necessary controls to prevent employees from exceeding the allowable hours worked thresholds. To determine if the threshold was exceeded, we compared the hours worked by DBHDS wage employees to the hours allowed by the Virginia Acts of Assembly.

### Comply with 1,508 Hour Rule for Wage Employees

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

DBHDS did not have adequate controls in place to ensure wage employees did not exceed 1,508 hours worked during the Commonwealth's Standard Measurement Period of May 1, 2017, through April 30, 2018. Three wage employees at the Hiram W. Davis Medical Center (Hiram W. Davis) and one wage employee at Central State Hospital (Central State) worked more than 1,508 hours, ranging between 1,546 to 1,718 hours, from May 1, 2017, to April 30, 2018. Both Hiram W. Davis and Central State did not have formal processes in place to monitor and track wage employees hours worked. As a result, management did not actively monitor and track those wage employees that exceeded the allowable hours worked threshold. Furthermore, staffing difficulties resulted in wage employees working excessive hours.

Chapter 1 §4-7.01 g. of the 2018 Virginia Acts of Assembly states that "State employees in the legislative, judicial, and executive branches of government, and the independent agencies of the Commonwealth, or an agency administering their own health plan, who are not eligible for benefits under the health care plan established and administered by the Department of Human Resource Management (DHRM) pursuant to Va. Code § 2.2-2818, may not work more than 29 hours per week on average over a twelve month period." DHRM guidance for determining compliance with this requirement defines the Commonwealth's Standard Measurement Period as May 1 through April 30 of the following year. Working 29 hours per week over a 12-month period equates to 1,508 hours. Failure to comply with Chapter 1 of the 2018 Virginia Acts of Assembly subjects DBHDS to potential financial penalties for violation of the Federal Affordable Health Care Act by allowing workers to work over the threshold and not receive healthcare benefits.

Management should comply with Chapter 1 §4-7.01 g. of the 2018 Virginia Acts of Assembly and ensure wage employees do not exceed 1,508 hours worked during the Commonwealth's Standard Measurement Period. To ensure compliance with these requirements, both Hiram W. Davis and Central State should implement formal processes over monitoring and tracking hours for wage employees, and reinforce the importance of not exceeding the annual hour limit.

### Why the APA Audits Compliance with the Commonwealth's Executive Leave Policy

DBHDS has at-will employees who must adhere to the Commonwealth's Executive Leave Policy, which is a different leave policy than the policy in effect for other Commonwealth employees. At-will employees receive 30 days of all-purpose leave to use during the Commonwealth's leave year. To determine compliance, we compared DBHDS' practices and processes in place for their at-will employees to the Commonwealth's Executive Leave Policy.

#### **Improve Controls Surrounding At-Will Employees**

**Type:** Internal Control

**Severity:** Significant Deficiency

**Repeat:** No

DBHDS' Human Resources does not ensure that they receive and maintain a written leave certification letter for their at-will employee stating that the employee has not exceeded their leave limit during the allotted time period. In addition, DBHDS was unable to provide documentation of the supervisor's approval of leave taken by the at-will employee during the allotted time period. At-will employees are individuals appointed by the Governor of Virginia, such as Cabinet members or agency heads.

The Commonwealth's Executive Leave Policy states that all at-will employees must obtain, in advance, proper approval from their supervisor before using any leave. Furthermore, it states that all at-will employees must certify, in writing, that they have not exceeded their established leave limit during the allotted time period. In addition, the agency's Human Resources Office must maintain this certification letter and make it available for review by the Auditor of Public Accounts.

Human Resources misunderstood the Executive Leave Policy requirements regarding leave certification letters and did not require the at-will employee to submit a leave certification letter. There is no documentation of supervisor approval of leave because the at-will employee's direct supervisor is no longer an employee at DBHDS Central Office; therefore, DBHDS cannot obtain support. Without maintaining the leave certification letter and supervisor's approval, DBHDS cannot provide assurance that the at-will employee complied with the provisions set forth within the Commonwealth's Executive Leave Policy.

Human Resources should ensure that their department and all at-will employees are familiar with requirements under the Commonwealth's Executive Leave Policy. Human Resources should ensure that their at-will employees annually submit a written certification letter establishing that they did not exceed their leave limits during the allotted time period. Additionally, Human Resources should maintain leave certification letters, and DBHDS should keep records of supervisor approval of leave.

## DEPARTMENT OF HEALTH

### Why the APA Audits the Supplemental Nutrition Program for Women, Infants, and Children

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) supports the health of pregnant women, infants, and children through better nutrition. The Department of Health (Health) is the Commonwealth's administrator of the WIC program, and is responsible for ensuring compliance with federal regulations. WIC program expenses totaled \$78 million in fiscal year 2018 and this program is included in our 2018 Single Audit of federal programs.

Health uses a third party service provider to facilitate benefit issuances and redemptions. To ensure that Health is properly monitoring this third party service provider, we evaluated whether management was obtaining, reviewing, and evaluating their service provider audit reports. We also compared various aspects of the WIC program to federal regulations in the areas of allowable costs, participant eligibility, monitoring, and reporting. We evaluated system access and controls for the eligibility system and compared their practices to the Security Standard.

### Perform Review of Service Organization Control Reports for Third Party Service Providers

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Health's Population Health Shared Administrative Services Division (Population Health) did not perform a review of the Service Organization Control (SOC) report for a third party service provider for the WIC program related to fiscal year 2017. A SOC report provides an independent description and evaluation of the service provider's internal controls. Population Health obtained the SOC report which reported material weaknesses in the service organization's internal control effectiveness; however, there is no evidence that Population Health reviewed the report or evaluated the internal control weaknesses. There was evidence that Population Health performed a SOC report review related to the same service provider for fiscal year 2018 and this review is still ongoing.

The Security Standard requires that agency heads remain accountable for maintaining compliance with the Security Standard for information technology equipment, systems, and services procured from providers, and agencies must enforce the compliance requirements through documented agreements and oversight of the services provided. Additionally, the CAPP Manual Topic 10305 – Internal Control, requires agencies to obtain assurance over the internal control environment of outsourced operations through a review of SOC reports. Lastly, Health's Office of Procurement and General Services (OPGS), Contract Administration Policy OPGS 5.01, states that contract administrators are responsible for obtaining and reviewing the SOC reports each year and providing this documentation to Internal Audit within 30 days of report receipt.

The lack of a review for fiscal year 2017 was the result of turnover in staff and there was no process in place to ensure this responsibility was delegated to another staff member. Given the significance of the service provider's role in the WIC program, internal control weaknesses reported in the SOC report could significantly impact the program. Without review and evaluation of the SOC report, Population Health cannot ensure that service providers' controls are designed, implemented, and operating effectively. This increases the risk that weaknesses in a provider's environment are not detected and affects Health's ability to ensure WIC program operations are in compliance with federal requirements.

Population Health should comply with requirements and internal policy with respect to review, evaluation, and documentation of SOC report reviews. If weaknesses are identified in SOC reports, at a minimum, Population Health should request a corrective action plan from the provider and work closely with Internal Audit to implement additional internal controls to reduce the risk to the Commonwealth.

#### **Ensure Timely Subrecipient Monitoring**

**Type:** Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Health's Office of Family Health Services (Family Health) did not issue a management decision regarding a subrecipient's audit finding timely in accordance with federal requirements. Family Health issued its management decision eleven months after the subrecipient's audit report.

Pursuant to the Code of Federal Regulations (CFR) 2 CFR §200.332 a federal pass-through entity must issue a management decision within six months of the audit report in response to any audit finding that pertains to its subrecipients' use of pass-through funds. This serves as a follow-up procedure to ensure the subrecipient adequately resolves the non-compliance. By delaying this communication, Family Health increases the risk that the subrecipient will not correct its non-compliance.

Family Health's Grants Compliance Manager position was vacant during the period under audit. This position is responsible for completing Family Health's subrecipient monitoring evaluations and decision letters. Given this situation, Family Health issued all management decision letters at once in October of 2017. To comply with federal requirements, Family Health should reassign responsibilities as necessary during extended staff vacancies. Family Health should prioritize federal compliance requirements when distributing temporary responsibilities.

#### **Comply with Federal Requirements over High-Risk Vendors**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Family Health does not follow the required process for identifying high risk vendors for the WIC program. Family Health has adopted a different approach which they believe is more effective; however, they did not obtain approval from the U.S. Department of Agriculture (USDA) as required.

Pursuant to 7 CFR §246.12(j)(3), state agencies must identify high-risk vendors at least once a year using criteria developed by the USDA's Food and Nutrition Service (FNS) and/or other statistically-based criteria developed by the State agency. All State agency-developed criteria must be approved by FNS.

Family Health is required to identify and investigate all high-risk WIC vendors on an annual basis. This targeted approach to vendor monitoring allows them to focus on vendors who are most likely to be non-compliant with WIC program regulations, or to commit fraud. Statistically-based criteria provide an objective, data-driven approach for vendor monitoring. Not using such criteria weakens the monitoring practices and Health's stewardship over federal funds.

Family Health adopted another approach because they believe the USDA-established statistical criteria are outdated and not relevant to current operations. If Family Health elects to use an alternative approach, Family Health should identify and document their criteria for identifying high-risk vendors and obtain approval from USDA. This will bring them into compliance and will allow more robust, risk-based monitoring over WIC vendors.

#### **Improve Controls over WIC Information System Access**

**Type:** Internal Control

**Severity:** Significant Deficiency

**Repeat:** No

Family Health performs a monthly review of WIC eligibility system access; however, their policy does not require Local Health Departments (LHD) to respond to the review if no changes are required. Consequently, there is no way to confirm if the LHD has performed the required review. In addition, Family Health has no formal process in place for granting or managing WIC Electronic Benefit Transfer (EBT) system access. This system is managed by a third party, but Health employees have read-only access to the system.

The Security Standard, Section AC-2 Account Management, requires that agencies review system accounts for compliance with account management requirements at least annually. Additionally, best practice indicates that agencies should maintain internal controls over the granting and removing of access to critical systems.

The lack of a positive confirmation of the review weakens the control because LHDs are not required to confirm that access is reasonable. This reduces Family Health's control over WIC eligibility determinations, which could result in benefit payments to ineligible individuals. Also, without a sound process to manage access to the WIC EBT system, Health does not have assurance that only authorized employees have system access.

Family Health's policies and procedures over monthly WIC eligibility system access reviews are not adequately designed. Family Health has not developed formal policies and procedures for managing WIC EBT system access.

Family Health should ensure system access management procedures are designed to provide adequate internal controls over critical WIC systems. At a minimum, they should require confirmation by each LHD that the monthly system access review is complete and accurate. Monthly reviews of other critical systems are managed and reviewed by Health's Office of Information Management (OIM) for all departments and LHDs. Family Health should consider having OIM include the WIC system access confirmation as part of these monthly certifications.

**Retain Documentation of WIC Financial Eligibility**

**Type:** Internal Control

**Severity:** Significant Deficiency

**Repeat:** No

LHDs do not consistently retain adequate documentation to support income eligibility for participants in the WIC program. LHDs did not retain adequate documentation of income eligibility determinations for six of 50 WIC participants (12%). Four of these participants were Medicaid eligible, but LHD staff did not retain documentation for the eligibility verification required for Medicaid recipients.

Pursuant to 7 CFR §246.7(d)(2)(v), WIC Applicants must provide documentation to show that they are income eligible to receive WIC benefits. While Federal regulations for WIC do not require retention of copies of this documentation, Family Health's internal WIC Policy CRT 05.2.1, Proof of Income, requires retention of documentation used to determine income eligibility. The lack of supporting documentation increases the chance that LHD employees will certify participants who do not meet the federal requirements for participation in WIC.

While Family Health's policies and procedures require document retention of proof of eligibility, they do not clearly designate what documentation LHD staff should retain, particularly when income eligibility is based on Medicaid participation. LHD staff do not always maintain evidence showing they verified an applicant was a current Medicaid participant. In addition, LHD staff are able to automatically confirm Medicaid participation using an electronic match feature within the WIC eligibility system; however, LHD Staff do not consistently use this feature.

Family Health should clarify policies and procedures to ensure LHD staff understand financial eligibility documentation requirements. At a minimum, they should include the types of documentation required and retention policy for each type of applicant. In addition, Family Health should encourage LHDs to use the electronic verification process thus eliminating the need to maintain documentation.



### **Ensure Adequate Separation of Duties when Certifying WIC Participants**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

LHDs do not consistently follow procedures for separation of duties exceptions when certifying participants for WIC. LHDs did not follow procedures for documenting exceptions for four out of 50 (8%) instances where the same LHD staff determined eligibility and issued food benefits.

Pursuant to 7 CFR §246.4(a) (27), Health must maintain policies and procedures prohibiting one employee from both determining eligibility and issuing food benefits for the same participant. These policies and procedures must provide alternative procedures when it is unfeasible to maintain this separation of duties. Family Health's internal WIC Policy ADM 06.0 prohibits the same individual from determining a participant's income eligibility and issuing food benefits to them on the same day. When operations require that one individual perform both of these tasks, the staff must document the exception in a log maintained at the local clinic. LHD directors must review these logs quarterly, and ensure they are complete.

LHD staff do not consistently complete the segregation of duties exception report. Without adequate separation of duties and supervisory review, there is an increased risk that a staff member could certify and provide fraudulent benefits. Family Health should ensure that LHD directors and staff follow all eligibility procedures. LHD staff should document all segregation of duties exceptions in the required log, and supervisors should review the log to ensure it is complete.

### **Comply with Virginia Administrative Code Requirements for Above-50-Percent Vendors**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Family Health does not follow the Virginia Administrative Code requirements for monitoring WIC retailers. Family Health is not performing a review of newly authorized retailers after six months to evaluate above 50 percent status. Above 50 percent vendors are retailers who derive more than 50 percent of their annual food sales from WIC benefits.

While federal regulations allow states to have vendors who earn more than 50 percent of their annual food sales from WIC sales, Virginia has elected to prohibit 50 percent vendors entirely. The Administrative Code (§12VAC5-195-310) prohibits Virginia WIC Vendors from being or becoming 50 percent WIC vendors. To ensure compliance with this state requirement, 12VAC5-195-310 requires a review of newly authorized WIC vendors for above 50 percent status after six-months in the WIC program. If it is determined that a retailer is an above 50 percent vendor, Family Health must remove the retailer from the WIC program. By not performing a six-month review as required, there is an increased risk that a vendor will reach the above 50 percent level and Family Health will not be aware of this in a timely manner.

Family Health considers it highly unlikely that an authorized WIC vendor will become an above 50 percent vendor. Therefore, they only perform an annual review based on a vendor report provided by USDA. Family Health also has other procedures in place to help minimize the likelihood of an above 50 percent vendor being in the program. Lastly, noncompliance with the Administrative Code requirements is also due to the lack of staff training on the requirements.

Family Health management should ensure staff are knowledgeable about and comply with specific requirements for the WIC program as set out in the Administrative Code. Family Health is in the process of updating the Administrative Code and should evaluate their policies and procedures for complying with the above 50 percent requirement as part of that process.

**Develop Procedures to Ensure Price Limits Are Accurately Recorded**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Family Health does not have a process in place to ensure maximum prices for WIC food items agree to the limits they approve. The daily file transmitted to the EBT vendor included maximum prices for yogurt of \$128-\$320 per container although the maximum prices in the WIC eligibility system were approximately \$4 per unit.

Pursuant to 7 CFR §246.4(a)(xvi), Family Health must establish allowable reimbursement levels for WIC food benefits and ensure compliance with the price limitations applicable to the vendor when processing benefit redemptions. By not ensuring the proper maximum price limits are in place, there is the risk vendors can charge unreasonably high prices for food benefits. Review of benefit redemption data during fiscal year 2018 indicated that this deficiency did not result in any excessive vendor charges.

Family Health staff approve maximum price limits on a weekly basis. Family Health added yogurt as a new food benefit during the audit period, but did not ensure the product's maximum price limits were correctly entered in the system. As a result, the WIC eligibility system transmitted erroneous price limits to the EBT processor. Family Health does not have controls in place to review the data actually sent to the EBT vendor.

Family Health should ensure maximum price limits are properly entered into the system and transmitted to the EBT vendor. This will help to ensure the maximum price limits are enforced as required.

### Why the APA Audits Information System Security

Health collects, manages, and stores significant volumes of personal and financial data within its mission critical systems. Because of the highly sensitive and critical nature of this data, Health's management must take all necessary precautions to ensure the integrity and security of the data in its systems. We compared Health's practices to those required by the Security Standard in the areas of web application security, oversight of sensitive systems, and information system access.

#### **Improve Contingency Management Program**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Health does not perform certain processes in their contingency management program required by the Security Standard and industry best practices. We identified two weaknesses and communicated them to management in a separate document marked Freedom of Information Act Exempt (FOIAE) under §2.2-3705.2 of the Code of Virginia due to them containing descriptions of security mechanisms.

The Security Standard requires agencies to implement certain controls that reduce unnecessary risk to data confidentiality, integrity, and availability in systems processing or storing sensitive information. By not meeting the minimum requirements in the Security Standard, Health cannot ensure the confidentiality, integrity, and availability of data within its systems.

Health should dedicate the necessary resources to implement the controls discussed in the communication marked FOIA Exempt in accordance with the Security Standard and best practices in a timely manner.

#### **Improve Web Application Security**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Health does not secure one of their sensitive systems with some of the minimum security controls required by the Security Standard and industry best practices. We identified four weaknesses and communicated them to management in a separate document marked FOIAE under §2.2-3705.2 of the Code of Virginia due to them containing descriptions of security mechanisms.

The Security Standard requires agencies to implement certain controls that reduce unnecessary risk to data confidentiality, integrity, and availability in systems processing or storing sensitive information. By not meeting the minimum requirements in the Security Standard, Health cannot ensure the confidentiality, integrity, and availability of data within its systems.

Health should dedicate the necessary resources to implement the controls discussed in the communication marked FOIA Exempt in accordance with the Security Standard and best practices in a timely manner.

### **Improve Timely Removal of Critical System Access**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2014)

Individual department supervisors do not have adequate controls in place to ensure employee separation forms (HR-14 forms) are transmitted to the Office of Human Resources (OHR) to ensure timely removal of system access. Policies and procedures require supervisors to complete the form and submit it to OHR prior to or immediately upon employee termination and OHR is to complete termination requirements within three days of receipt. We found the following deficiencies in the payroll and human resources processes:

- Payroll system access was removed four to 47 days late for six out of 11 (55%) employees;
- Benefits system access was removed eight to 52 days late for three out of nine (34%) employees; and
- Network access was removed five to 11 days late for nine out of 38 (24%) employees.

The Security Standard, Section 09.1 AC-2 (h), requires notifying account managers when information system users are terminated, transferred, or information system usage or need-to-know changes. In addition, Security Standard, Section 09.1 AC-2-COV (2.f), states that each agency shall promptly remove access when no longer required. Health internal policies also state the HR-14 should be processed within three business days of receipt by OHR.

Terminated employees who still have network access may be able to access other critical programs since it acts as the gateway to all the agency's systems. Untimely removal of access to payroll and benefits systems increases the risk that employees will use their inappropriate access to make changes to payroll related items. These weaknesses elevate the risk for malicious activity to occur within Health.

There are a number of factors contributing to this issue. When an employee terminates it is the responsibility of the work unit to advise OHR of the departure. Health employs over 6,000 employees and had over 500 separations during fiscal year 2018, and due to Health's decentralized nature, notification does not always happen timely. In addition, OHR does not have oversight authority to monitor this process and; therefore, cannot confirm that supervisors are adhering to the policy. The following specific instances contributed to the untimely removal of system access for terminated employees:

- Individual work units did not properly complete the HR-14 for two of 38 (5%) terminated employees;
- Individual work units did not submit the HR-14 timely to OHR for 27 of 38 (71%) terminated employees;
- Administrative offices (OIM, Office of Risk Communication and Education, OPGS, Office of Environmental Health Services, and Family Health) did not properly complete the HR-14 for seven of 38 (18%) terminated employees; and,
- OHR did not process the HR-14 timely for four of 38 (11%) terminated employees.

This issue has continued over several years, and timely completion and submission of the HR-14 seems to be an underlying cause for untimely access removal. Due to their critical role in the termination process, OHR management should review and update the process surrounding the completion and routing of the HR-14. This update should include adoption of more stringent requirements for individual department supervisors to ensure timely completion and routing to OHR.

#### **Perform Financial System Access Reviews**

**Type:** Internal Control

**Severity:** Significant Deficiency

**Repeat:** No

Health does not review access to its internal accounting system monthly as required by their policies and procedures. Individual costs centers and departments are required to review accounting system access for reasonableness on a monthly basis and certify this through Health's security portal; however, some local agencies and departments are not performing this access certification and systems security staff are not performing any follow-ups. One of eight costs centers (12%) did not complete the required system access review.

Health's procedures require that each cost center and department certify user account and access information through the Information Security Portal no later than the 10th of the following month. Health is a decentralized agency, which makes periodic access reviews essential to help the agency ensure all individuals with access are reasonable and necessary. Insufficient access management increases the risk of unauthorized access to the accounting system, which could allow for improper transactions and unreasonable access to agency data.

While Health has updated and automated the procedures for access reviews to make the review process more efficient, the procedures do not include a process for ensuring review completion. Health should update their procedures to include follow up with delinquent cost centers and departments.

### Why the APA Audits Hours Worked by Wage Employees

Health employs a significant number of wage employees who are not eligible to participate in the state health insurance plan. Because of the financial penalties associated with violating Federal laws pertaining to health insurance coverage, Health management must take necessary precautions to prevent employees from exceeding allowable hours worked thresholds. To determine if the threshold was exceeded, we compared the hours worked by Health wage employees to the hours allowed by the Affordable Care Act and the Virginia Acts of Assembly.

### **Develop and Implement Policy for Monitoring Part-time Employee Hours**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Health does not adequately monitor employee hours to ensure part-time employees are limited to 1,508 hours annually. For the look-back period from May 1, 2017, through April 30, 2018, the agency had five part-time employees with more than 1,508 hours worked in the period. Although Health has procedures to generate monthly monitoring reports, these procedures and the monitoring process need to be strengthened in several areas.

The Affordable Care Act limits the maximum number of hours employers can allow part-time employees to work to 29 hours weekly or 1,508 hours annually. Additionally, for certain Commonwealth employees, Chapter 1 §4-7.01 g of the 2018 Virginia Acts of Assembly states that they may not work more than 29 hours per week on average over a twelve-month period. Since Health has over 700 part-time employees, it is critical that the agency effectively and efficiently monitor hours worked for these employees. By allowing a part-time employee to work over the 1,508-hour limit, Health may be required to incur the costs of providing benefits to part-time employees meant for full-time employees and the agency can be subject to any related penalties.

There are multiple factors contributing to this issue. First, Health's payroll department does not post monthly monitoring reports timely. As an example, the report for March 2018 was not posted until the end of May 2018. Also, Health does not have a procedure in place for the payroll department to notify managers when the report is available. Lastly, there are no procedures that require the responsible supervisors to review the reports to ensure compliance with the 1,508-hour rule.

Health should strengthen policies and procedures related to the monitoring of part-time hours. Health should have a procedure to require managers to review the monitoring reports generated by the payroll department. It is imperative that district managers maintain an awareness of their part-time employees' total hours worked for the year. In addition, the payroll department should be required to post the monitoring reports timely and communicate the report posting to allow district managers ample time for review prior to creating future work schedules.

## DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

### Why the APA Audits the Annual Accrual Process

The Department of Medical Assistance Services' (Medical Assistance Services) medical claims payable and related federal receivable accrued at year-end are material to the Commonwealth's CAFR. As a result, it is important for Medical Assistance Services to have a thorough understanding of significant financial reporting policies and the information it provides to Accounts for inclusion in the CAFR. To evaluate Medical Assistance Services' claims payable and related federal receivable, we reviewed Medical Assistance Services' accrual methodology and supporting documentation used to prepare the accrual estimate.

### Strengthen Controls over Year-End Accrual Reporting

**Type:** Internal Control

**Severity:** Material Weakness

**Repeat:** No

Medical Assistance Services needs to strengthen controls over year-end accrual reporting information submitted to Accounts. Medical Assistance Services' accrued claims calculation contained several errors that resulted in a material misstatement of the accrued claims payable and related federal receivable reported to Accounts for inclusion in the Commonwealth's financial statements. Specifically, the following errors were found:

- Staff incorrectly entered data into a spreadsheet resulting in a \$3.7 million understatement of the total claims payable liability. This error also impacted federal expenditures, general fund expenditures, federal receivables, and federal revenue.
- Staff incorrectly included prior year amounts in the pharmacy rebate forecast resulting in a \$6.1 million overstatement of the total claims payable liability. This error also impacted federal expenditures, general fund expenditures, federal receivables, and federal revenue.
- The Budget Division revised its accrual methodology and did not inform the Fiscal Division which resulted in a \$17.8 million understatement of the federal claims payable liability and a \$17.8 million overstatement of the general fund claims payable liability. This error also impacted federal expenditures, general fund expenditures, federal receivables, and federal revenue.
- Staff incorrectly entered data into a spreadsheet resulting in a \$1.4 million overstatement of the general fund claims payable liability. This error also impacted general fund expenditures.

Medical Assistance Services' accrued claims calculation has been prepared by different staff for the last three years, and both the Fiscal Division and the Budget Division lost significant resources in key positions during the time period when the financial information was prepared. The lack of

communication between the Budget Division and the Fiscal Division on changes in the methodology also contributed to some of these errors. The errors listed above resulted in multiple revisions to the information which affects the efficiency of the process, both for Medical Assistance Services as well as Accounts.

There was one additional financial reporting issue related to a liability for federal Medicaid disallowances where the state will have to return money to the federal government. Medical Assistance Services incorrectly classified this material liability in terms of current and prior year activity and had to revise this information and submit corrected information to Accounts.

Policies and procedures over financial reporting information, as a best practice, should be detailed and thorough with a sufficient review process to prevent and detect potential errors or omissions. Also as a best practice, the Fiscal and Budget Divisions should collaborate to complete the year-end accrual information reported to Accounts for inclusion in the Commonwealth's financial statements.

Medical Assistance Services should review and strengthen their policies and procedures over the preparation of year-end financial reporting information for Accounts. These procedures should include a supervisory review to help detect and prevent errors and, ideally, eliminate the need for multiple revisions. As part of this process, the Budget Division and the Fiscal Division should collaborate as needed to ensure there is a common understanding of significant financial reporting policies and that submitted information is accurate. Given the significance of Medical Assistance Services' financial activity, it is also important that they consult with Accounts on financial reporting issues that may be complex or unusual to ensure both agencies have a thorough understanding of the nature of the activity and agree on the correct financial reporting treatment.

#### **Why the APA Audits Access Management for the Claims Processing System**

The claims processing system is accessible from the web, stores protected health information for over one million individuals, and is used to process over \$10 billion in medical claims annually. While the claims processing system is operated by a contractor, Medical Assistance Services is the system owner and is responsible for ensuring the system is managed in accordance with the Security Standard. To evaluate Medical Assistance Services' management of system access for the claims processing system, we compared internal control practices to those required by the Security Standard.

#### **Remove Access to the Claims Processing System in a Timely Manner**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2017)

Medical Assistance Services did not remove access to the claims processing system timely for individuals who no longer needed access. Specifically, six of eight employees tested did not have their



system access disabled within 24 business hours of separation. Additionally, we identified three other employees whose access was not removed within 24 business hours. The nine employees in question retained their system access between three and 72 days after separation.

Medical Assistance Services' IT Access Control AC-1 Policy Section A11(b)(i), requires that "all user accounts must be disabled immediately upon separation or within 24 business hours upon receipt by the Office of Compliance and Security." In addition, the Security Standard, Section 8.13, states an organization must disable information system access within 24 hours of employee separation and terminate any authenticators or credentials associated with the individual. Not timely disabling access to a web based mission critical system threatens the data integrity of the system. If separated employees retain access to the claims processing system, users are potentially able to view, copy, and edit sensitive information.

Medical Assistance Services' Office of Compliance and Security (Compliance and Security) is not suspending separated employees' access in a timely manner due to ineffective and untimely communication with Medical Assistance Services' Human Resources Division. Additionally, disabling access to the claims processing system requires input from multiple employees within Compliance and Security. When combined with the communication issues noted above, the manual nature of the process often prevents timely removal of separated users.

Compliance and Security and the Human Resources Division should establish effective, regular communication to report staff changes to those individuals responsible for managing system access. In addition, Compliance and Security should ensure compliance with its Access Control Policy and the Security Standard by removing users' access as required.

#### Why the APA Audits Collection Efforts

Medical Assistance Services has several program integrity and utilization units that have the combined responsibility to identify suspected fraud, waste, and/or abuse across the Medicaid program. In cases where these units find that funds are to be returned, Medical Assistance Services has a set of procedures to follow to increase the likelihood that overpayments are collected. To evaluate collection efforts, we compared Medical Assistance Services' actions to its internal policies and procedures.

#### **Continue Improving the Accounts Receivable Collection Process**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2016)

Medical Assistance Services' Fiscal Division needs to continue to improve their collection process for overpayments. Although improvements have been made in this area since our last audit, we found the following instances where the Fiscal Division did not follow policies and procedures for collecting overpayments identified by the various Program Integrity reviews.

- For two of seven (29%) overpayments identified by the Provider Review Unit, the invoicing letter was not sent to the provider in a timely manner.
- For 13 overpayments identified by the Recipient Audit Unit, nine (69%) final letters were not sent in a timely manner, and one final letter was not mailed at all. In addition, six of these cases were referred to collections several months late.
- For one of five (20%) overpayments identified by the Utilization Review Unit, the invoicing letter was not sent to the provider in a timely manner.

Medical Assistance Services, to comply with the Virginia Debt Collection Act, Code of Virginia §2.2-4800-4809, established procedures to pursue collection of overpayments from recipients and providers. These procedures specify timeframes in which overpayment notice letters and invoicing letters must be sent to recipients and providers. In addition, the Accounts Receivable Unit refers uncollectable overpayments to the Virginia Department of Taxation, the Office of the Attorney General, and the Commonwealth's collection agency within specified timeframes. By not following established procedures designed to meet Commonwealth requirements, Medical Assistance Services is potentially not collecting money owed from recipients and providers.

According to management, the Accounts Receivable Unit has been understaffed for several years, which has caused a backlog in this area. Fiscal year 2018 has been a transitional period for the Accounts Receivable Unit as they have focused on clearing the backlog of collections and streamlining operations. Significant improvements have been made, but some issues remain. Additionally, the implementation of an automated overpayment processing function has been delayed due to a shift in agency priorities, and this has impacted the Unit's ability to completely resolve these issues. Medical Assistance Services should continue to strengthen collection processes and ensure they are performed timely and in accordance with policies and procedures.

#### **Why the APA Audits Compliance with the Statement of Economic Interest Requirements**

Medical Assistance Services has designated over one hundred employees in a position of trust. The Code of Virginia requires all individuals in a designated position of trust to complete the Statement of Economic Interest (SOEI) Disclosure Forms and the related training. To evaluate Medical Assistance Services' compliance with the Code of Virginia, we compared its practices to those required by the Code of Virginia.

### **Ensure Employees Complete Required Conflict of Interest Training**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes, partial repeat, (first issued in fiscal year 2017)

**Prior Title:** Create Policies and Procedures to Ensure Compliance with Statement of Economic Interest Requirements

Medical Assistance Services did not ensure employees completed the required conflict of interest orientation course within the timeframe outlined in the Code of Virginia. Specifically, 18 out of 128 (14%) employees who hold positions of trust did not complete the Conflict of Interest orientation course.

Pursuant to Code of Virginia §2.2-3128 through §2.2-3131, each state filer shall attend the orientation course within two months after he or she becomes a state filer and at least once during each consecutive period of two calendar years commencing on the first odd-numbered year thereafter. In addition, the Code of Virginia §2.2-3129 requires agencies to keep a record of attendance that includes the specific attendees, each attendee's job title, and the dates of attendance for a period of not less than five years after each course is given.

By not complying with these requirements, Medical Assistance Services could be susceptible to actual or perceived conflicts of interest that would impair, or appear to impair, the objectivity of certain decisions made by employees in positions of trust. Additionally, not completing the conflict of interest orientation course may prevent Medical Assistance Services employees from recognizing or properly disclosing a conflict of interest.

Although the Human Resources Division has developed and implemented policies and procedures to guide management through the SOEI process, Medical Assistance Services did not adequately monitor employees or hold them accountable for compliance with these policies and procedures.

The Human Resources Division should ensure compliance with its internal policy and the Code of Virginia by monitoring all employees designated in a position of trust to ensure they complete the required conflict of interest orientation course within two months of becoming a filer and once within each consecutive period of two calendar years thereafter. The Human Resources Division should also maintain a record of such attendance.

## DEPARTMENT OF SOCIAL SERVICES

### Why the APA Audits Compliance with Federal Requirements

Social Services spends almost two billion in federal dollars annually, with over 80 percent of these funds being passed through to a sub-recipient. Not complying with the federal requirements for these funds could lead to the loss of federal funding. We reviewed Social Services' compliance with federal requirements for the following programs: Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance, and Low Income Home Energy Assistance.

### **Improve Controls over Income Verification for the Temporary Assistance for Needy Family Program**

**Type:** Internal Control and Compliance

**Severity:** Material Weakness

**Repeat:** No

Social Services does not have a control in place to ensure the Income Eligibility and Verification System (IEVS) is used when determining eligibility for TANF participants. During our review of TANF cases, we determined that the use of IEVS was highly recommended to local agencies processing TANF applications, but not required. Additionally, during our review we noted that three out of 29 TANF (10%) cases selected for review did not have adequate support for the income verified manually.

45 CFR §205.55 requires agencies to collect income information through IEVS. Additionally, the TANF Manual created by Social Services and maintained on Social Services' webpage requires that the information received from IEVS or other system inquiry to be verified from an independent source, which can include pay stubs and written confirmation from source of income.

By not appropriately verifying income for TANF participants, Social Services cannot verify that participants in the TANF program have met all eligibility requirements. We consider this to be a material weakness as Social Services may have provided TANF benefits to ineligible recipients.

Due to the implementation of Social Services' new case management system, Social Services is not requiring local agencies to complete the income verification through the data match of IEVS. Social Services should require local agencies processing TANF applications to utilize IEVS for verifying income. In addition, Social Services should implement a control to ensure that IEVS is utilized and that income verified through outside sources is documented and retained.

### **Update the Work Verification Plan for the Temporary Assistance for Needy Family Program**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services did not update the work verification plan for the TANF program when Social Services implemented a new case management system. Social Services uses the case management system to mark work eligible participants, track the actual participation hours, and maintain the supporting documentation for this review. This information is determined and maintained by local Social

Services employees. Without an up to date work verification plan, we could not determine that TANF cases were verified in accordance with the approved work verification plan.

45 CFR §261.63(c) requires agencies to submit for approval an amended work verification plan by the end of the quarter in which a procedure or internal control has changed relating to its' verification procedures. By not having an up to date work verification plan, it cannot be determined that Social Services complied with their approved work verification plan.

As agencies are not required to update the work verification plan on a regular basis after the initial plan is approved, Social Services did not update the work verification plan when the new case management system was implemented. Social Services should update the TANF work verification plan to reflect its current internal controls and submit the plan for approval.

### **Improve Controls over Federal Performance Reporting**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services does not have adequate controls in place to ensure accurate federal reporting for two TANF performance reports, the ACF-199 "TANF Data Report" and ACF-209 "SSP-MOE Data Report." These reports are submitted quarterly and utilize a recently implemented case management system to create the reports. During our review, we found two key line items, Receives Subsidized Child Care and Work Participation Status, were not reported according to information maintained in the case management system.

45 CFR §265.7(b) requires states to have complete and accurate reports which means that the reported data accurately reflects information available in case records, data is free of computational errors, and are internally consistent. Reporting potentially inaccurate or incomplete information prevents the U.S. Department of Health and Human Services' Division of Administration for Children and Families from adequately monitoring Social Services' work participation rates and overall performance for the TANF program. In addition, if Social Services is found to not be meeting minimum work participation rates, a penalty of up to 21 percent of the awarded grant can be assessed.

These reporting errors can be attributed to conversion issues from legacy systems into the new case management system as well as implementation difficulties with the new system. Social Services should continue working with their Division of Enterprise Systems to correct system deficiencies to ensure all information submitted in federal reports is accurate.

### **Obtain Federal Authorization before Deviating from Cash Management Requirements**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

In response to the threat of federal government shutdown, Social Services drew down approximately \$21.6 million dollars in excess federal funds in January 2018, which were not disbursed immediately. Social Services contacted the U.S. Department of Health and Human Services requesting guidance prior to the drawdown, but the U.S. Department of Health and Human Services did not give explicit written permission to draw down excess funds.

The Cash Management Improvement Act requires Social Services to draw down funds based on prescribed funding techniques to limit the amount of time between the draw down and use of those funds. By drawing down and holding funds rather than disbursing them, Social Services could earn interest on the funds which creates a liability for the Commonwealth.

While Social Services materially complied with the Cash Management Improvement Act, Social Services made a management decision to draw down additional funds to ensure operations would continue in the event funds would not be available from the federal government during a shutdown. In the future, Social Services should obtain explicit consent from the Federal government when deviating from cash management requirements.

### **Improve the Billing Process**

**Type:** Internal Control

**Severity:** Significant Deficiency

**Repeat:** No

Social Services did not submit reimbursements for Medicaid administrative costs to Medical Assistance Services timely. We noted three months of the fiscal year where Social Services did not request a reimbursement request timely, with each request being delayed by several months. For example, the June 2018 request was not submitted to Medical Assistance Services until September 2018.

CAPP Manual Topic 20505 states that agencies should have systems in place to bill timely, and accounts should be billed when goods are provided or services rendered. Social Services' Policy 401-Federal Cash Management states that Medicaid reimbursements are to be completed and submitted to the respective agency on a monthly basis.

Due to turnover in the Cash Management Department of Social Services, billings to Medical Assistance Services were delayed. By not submitting invoices timely, Social Services cannot guarantee timely reimbursement from Medical Assistance Services. Additionally, by not requesting federal funds in a timely manner, Social Services relies upon state monies, which may result in budget shortages.

Social Services should enforce current policies relating to Medicaid billings to ensure reimbursements are submitted within the prescribed time frame. Additionally, Social Services should

ensure that adequate succession planning measures are in place to mitigate the consequences of employee turnover.

#### **Improve Controls over Federal Reporting**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services does not have adequate controls in place to ensure accurate federal reporting on the FNS-209 “Status of Claims Against Households” Report (FNS-209). This report is submitted quarterly and utilizes a recently implemented case management system to create the report. During our review, Social Services was unable to provide documentation validating some lines on the FNS 209 report for the first and second quarter of the federal fiscal year. Social Services has been using manual processes to adjust data obtained from the system; however, this process could not be reproduced for our review. Social Services’ Finance Division and Division of Enterprise Systems have been working with the Department of Food and Nutrition Services (FNS) to address the system deficiencies. These system deficiencies can be attributed to conversion issues from legacy systems into the new case management system as well as implementation difficulties. Additionally, Social Services does not have policies and procedures for completing this report.

7 CFR §273.18 (m) requires agencies to maintain a system for monitoring recipient claims against households that maintains claims records and corresponding receivable information. The system must also be able to produce summary reports and reconcile to supporting records. Reporting potentially inaccurate or incomplete information prevents FNS from adequately monitoring the status of claims against households. Additionally, using manual processes for federal reporting is inefficient and has a higher risk for errors.

Social Services should continue working with their Division of Enterprise Systems and FNS to correct system deficiencies to ensure all information submitted in federal reports can be sufficiently validated. Social Services should also create procedures over the reporting process to ensure accurate reporting of claims against households.

#### **Improve Process and Controls over Subrecipient Monitoring**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services Division of Community and Volunteer Services (Volunteer Services) is not consistently monitoring subrecipients in accordance with federal requirements. Since January of 2018, Volunteer Services has not been monitoring subrecipients to ensure that federal funds passed through to them are audited as required. In addition, Volunteer Services has not reviewed audit reports to determine if management decisions should be issued as required.

According to 2 CFR 200.331(d), pass-thru entities are required to monitor fiscal and performance reports and must verify that every subrecipient is audited as required. Per 2 CFR 200.501(a-b), a non-Federal entity that expends \$750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year.

Volunteer Services is unable to provide assurance that audits are performed for all subrecipients expending \$750,000 or more from January of 2018 to present. Without this assurance Volunteer Services is unable to show it is completely meeting audit requirements of 2 CFR part 200, subpart F., which includes: that the required audits are completed within nine months of the end of the subrecipient's audit period; issuing a management decision on audit findings within six months after receipt of the subrecipient's audit report; and ensuring that the subrecipient takes timely and appropriate corrective action on all audit findings.

Volunteer Services had a key employee retire in January of 2018, without ensuring all job duties were delegated to an appropriate successor. Our review determined a successor has been named and is waiting on approval from Human Resources to begin monitoring subrecipients for the required audits.

Volunteer Services should ensure that subrecipients are monitored in accordance with all federal requirements. Volunteer Services should also have succession plans in place to ensure that key activities continue when there is turnover.

#### **Ensure that Subrecipient Reviews Adhere to Monitoring Plan**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services is not adhering to the established approach for monitoring subrecipients. Volunteer Services was unable to produce quarterly reports used to brief executive management on Volunteer Services' subrecipient monitoring activities for each division within Social Services. Further, we noted that Social Services' Division of Benefit Programs (Benefit Programs) is not consistently adhering to the established monitoring plan when monitoring subrecipients. It was determined that not all local consultants tasked with subrecipient reviews are utilizing the same required tools and reports in their subrecipient monitoring process.

2 CFR 200.331(d) requires pass through entities to monitor the activities of subrecipients as necessary to ensure that the sub-award is meeting grant requirements. To aid in this process and mitigate risk, Social Services develops annual monitoring plans which outline the review process and reports the results of the reviews to executive management quarterly.

Without providing reports to executive management, we are not able to determine if Volunteer Services is assessing each of their division's completed subrecipient reviews and if executive management is acting upon possible deviations. Additionally, the lack of consistency in Benefit Programs following their monitoring plan furthers the possibility of monitoring reviews not meeting the necessary requirements set forth in the noted criteria.



Both Volunteer Services and Benefit Programs have had turnover in key positions resulting in lack of understanding in program requirements and processes performed to monitor subrecipients. With regard to Benefit Programs, we noted that not all consultants are following the same guidelines set forth in the fiscal year 2018 Monitoring Plan. Specifically, local consultants are not consistently using the monitoring tools that Benefit Programs requires.

Social Services should ensure that all Divisions are adhering to the established approach for monitoring subrecipients. Specifically, Volunteer Services should work to ensure progress reports are provided to executive management for review and monitoring of subrecipients. Further, Benefit Programs should ensure that all consultants are performing reviews as outlined in the monitoring plan.

#### Why the APA Audits Information System Security

Social Services is responsible for managing federally mandated eligibility programs for the Commonwealth of Virginia, such as TANF, Supplemental Nutrition Assistance, Medicaid, and Child Support Services. In order to manage the significant volume of personal and financial data, Social Services relies on IT systems for the collection, management, and storing of data. Due to the sensitivity of the data, appropriate policies, procedures, and security controls in accordance with the Security Standard, federal regulations, and industry-specific best practices must be in place to ensure its protection from malicious intent and disastrous events. To evaluate the controls surrounding information systems, we compared the practices of Social Services to those required by the Security Standard.

#### Continue Improving Database Security

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Partial (first issued in fiscal year 2016, with significant progress in all but one area)

**Prior Titles:** Continue Improving Database Security for Case Management System and Improve Database Security for Financial Reporting System

Social Services does not perform certain security procedures over the databases supporting its financial reporting system and case management system in accordance with the Security Standard and industry best practices. Social Services resolved three out of four prior year database weaknesses for its case management system and four out of five prior year database weaknesses for its financial reporting system. The corrective actions to remediate the remaining weakness in the databases took longer than Social Services anticipated. We communicated the details of the remaining weakness for both systems to management in a separate document marked FOIAE under §2.2-3705.2 of the Code of Virginia due to its sensitivity and description of security controls.

The Security Standard requires agencies to implement certain minimum controls to safeguard data that is stored in database systems. This serves to reduce the unnecessary risk to data

confidentiality, integrity, and availability. By not implementing the controls discussed in the FOIAE communication, the systems' databases are not secure against known vulnerabilities. This increases the risk for malicious users to exploit those vulnerabilities and compromise sensitive Commonwealth data.

Social Services should dedicate the necessary resources to ensure that database procedures and controls align with the requirements in the Security Standard. Additionally, Social Services should consistently implement controls across all of its systems. Doing this will help maintain the confidentiality, integrity, and availability of sensitive and mission critical data.

**Develop Records Retention Requirements and Processes for Case Management System Electronic Records**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services does not have electronic records retention requirements for its case management system. Social Services is working to document and implement specific record retention requirements for the federal benefit programs based on federal regulations. Social Services experienced delays with developing and implementing corrective actions due to competing priorities of Medicaid expansion and other corrective actions within the IT environment. We communicated the deficiencies to management in a separate document marked FOIAE under §2.2-3705.2 of the Code of Virginia due to it containing descriptions of security mechanisms.

Federal regulations require different record retention requirements for different federal programs. Additionally, the Virginia Public Records Act (§42.1-91 of the Code of Virginia) requires each agency to be responsible for ensuring that its public records are preserved, maintained, and accessible throughout their lifecycle, including converting and migrating electronic records as often as necessary so that information is not lost due to hardware, software, or media obsolescence or deterioration. Furthermore, the Security Standard, Section CP-9-COV, requires for every IT system identified as sensitive relative to availability, an agency implement backup and restoration plans that address the retention of the data in accordance with the records retention policy.

Retaining records longer than necessary causes the Commonwealth to spend additional resources to maintain, back-up, and protect the information. Additionally, without documenting and implementing records retention requirements, Social Services may not be able to ensure that backup and restoration efforts will provide mission essential information according to recovery times.

Social Services should continue identifying retention requirements for the data within its case management system. Additionally, Social Services should implement a process, whether a manual process or automated control, to ensure consistent compliance with the retention requirements the agency identifies for each data set within the IT system.

### **Improve IT Risk Management and Contingency Planning Program**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services does not maintain effective Risk Management and Contingency Planning documentation. Specifically, Social Services does not have IT System and Data Sensitivity Classifications for five systems (13%), IT System Risk Assessments (RA) for three systems (8%), and System Security Plans (SSP) for two systems (5%) out of a total of 40 sensitive systems. Additionally, Social Services does not annually test its COOP to verify it can obtain and use IT resources to support contingency procedures.

The Security Standard, Section 4, requires Social Services classify the IT system as sensitive if any type of data handled by the system is sensitive based on confidentiality, integrity, or availability. The Security Standard, Section 6.2, also requires the agency to conduct and document a RA for each IT system classified as sensitive at least once every three years. Additionally, the Security Standard, Section PL-2-COV, requires Social Services document a SSP for the IT system. Furthermore, the Security Standard, Section CP-4, requires Social Services test the COOP on an annual basis or more frequently to determine the effectiveness of the plan and the organizational readiness to execute the plan.

Without documenting risk management information for all of its sensitive systems, Social Services cannot accurately determine which information security controls to implement. This may result in Social Services spending too many resources on insignificant controls or not having sufficient controls to protect sensitive information. Additionally, the absence of regular COOP tests may result in Social Services not having the IT resources necessary to perform its essential business functions or recover its IT systems in a timely manner in the event of an emergency or disaster. This may result in unnecessary delays when attempting to restore IT services to the agency's essential business functions.

Social Services experienced delays in finalizing the remaining IT risk management documentation and performing the COOP test due to competing priorities within the IT environment. The agency had deadlines to address Medicaid expansion and resolve issues from an Internal Revenue Service review.

Social Services should dedicate the necessary resources to complete Risk Management documentation for its sensitive systems and perform a COOP test that verifies the agency has the necessary IT resources to support their continuity management program. Doing this will help to ensure the confidentiality, integrity, and availability of the agency's sensitive systems and mission essential functions.

### **Remove Separated Employees' Access to Critical Systems in a Timely Manner**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** No

Social Services did not remove employee access from critical systems in a timely manner for certain separated employees. We reviewed Social Services' listing of 154 employees that separated

during fiscal year 2018 and found six instances, across three critical systems, of Social Services not promptly removing an employee's access after their separation.

The Security Standard, Section AC-2-COV (2.f), requires each agency to promptly remove access when no longer required. In addition, CAPP Manual Topic 10305 related to internal controls requires agencies to retest their key controls to ensure that they are still working for all significant fiscal processes that have not changed since the prior year.

Without the prompt removal of separated employee access, there is an increased risk of critical or sensitive data being improperly manipulated or unauthorized transactions occurring. Potential unauthorized access threatens the data integrity of the system as these users could view, copy, and edit sensitive information.

While management has an established process for removing employees as they separate from Social Services, management does not periodically compare its listing of separated employees to its access listings for critical systems. Social Services' management should develop a process for monitoring its access removal control to ensure that access is removed timely when an employee terminates.

#### Why the APA Audits Compliance with the Statement of Economic Interest Requirements

Social Services has designated over 20 employees in a position of trust and some of these employees negotiate and award multi-million contracts on behalf of the Commonwealth. The Code of Virginia requires all individuals in a designated position of trust to complete the SOEI Disclosure Forms and complete the related training. To evaluate Social Services' compliance with the Code of Virginia, we compared its practices to those required by the Code of Virginia.

#### **Ensure Statement of Economic Interest Filers Complete Required Training**

**Type:** Internal Control and Compliance

**Severity:** Significant Deficiency

**Repeat:** Yes (first issued in fiscal year 2017)

**Prior Title:** Obtain and Retain Statement of Economic Interest Training Records

Social Services SOEI Coordinator is not ensuring that employees within a position of trust complete the required SOEI training every two years. Thirteen out of 31 filers (42%) did not complete the training in the past two years.

The Code of Virginia §2.2-3128 through §2.2-3131 requires that each SOEI filer complete Conflict of Interest Act training at least once every two years. This training is designed to help filers recognize potential conflicts of interest. As of December 1, 2015, the Council offers an orientation video on their website, which satisfies this requirement. Filers who register and watch the entire video get credit for taking the training.

Social Services does not ensure that its employees are completing the training as required and may be limited in its ability to hold its employees accountable for not knowing how to recognize a conflict

of interest and how to resolve it. Additionally, filers could be subject to penalties for inadequate disclosure as outlined at §2.2-3120 through §2.2-3127.

Social Services' does not have written policies and procedures relating to SOEI training requirements. Additionally, Social Services' relies on an internal system to track and notify filers of the training requirement.

Social Services' should create, implement, and maintain written policies and procedures to meet Code of Virginia requirements for the SOEI training. These policies should incorporate guidance issued by the Commonwealth's Ethics Council. Additionally, as required by the Code of Virginia, the SOEI Coordinator should monitor all employees designated in a position of trust to ensure they complete the required training once within each consecutive period of two calendar years and maintain a record of such attendance.

#### Why the APA Audits Compliance with Employment Eligibility Guidelines

Social Services employs over 1,700 employees. Noncompliance with Federal government employment eligibility guidelines could result in financial penalties. To determine compliance with the employment eligibility process, we reviewed Social Services' processes and forms used to verify both employment eligibility and identity. We compared their processes to those required by the Federal government and the Code of Virginia.

#### **Improve Processes and Controls over Employment Eligibility**

**Type:** Internal Control and Compliance

**Severity:** Deficiency

**Repeat:** No

Social Services' Department of Human Resources (Human Resources) does not have a sufficient process and controls over the employment eligibility process. Human Resources was unable to provide the personnel file for one out of 30 employees tested. Of the remaining 29 tested, we noted the following:

- Three employees (10%), signed their I-9 one day or more after their first day of employment.
- For six employees (20%), required information, such as driver's license or Social Security cards listed in section two, was not adequately documented.
- For three employees tested (10%), the second page of the I-9 form was not properly completed.

- We further noted Human Resources is not consistently copying documents provided by new hires for identification. Seven out of the 29 tested (24%) were noted to have different standards applied in copying items such as Social Security cards.

The Immigration Reform and Control Act of 1986, requires that all employees hired after November 6, 1986, have a Form I-9 completed to verify both employment eligibility and identity. This requirement ensures that employers hire only individuals who may legally work in the United States. Per the Handbook for Employers M-274, issued by the U.S. Citizenship and Immigration Services (M-274), Form I-9 must be retained for a period of at least three years from the date of hire or for one year after the employee is no longer employed, whichever is longer. Additionally, per the M-274, “if you choose to make copies of the documents, do so for all employees, regardless of national origin or citizenship status, or you may be in violation of anti-discrimination laws.” Not complying with federal and state statutes could result in substantial civil and/or criminal penalties and debarment from government contracts.

Human Resources has experienced high turnover in the past fiscal year and management has not adequately trained employees or communicated policies and procedures regarding this process. The current policy manual does not fully cover this process.

Human Resources should update their current policy manual to include all required employment eligibility practices. Human Resources should ensure the policies and procedures are communicated to employees and that employees are trained on the process. Human Resources should ensure that employment eligibility is completed for all applicable employees, and that such documentation is retained for the required period of time. Further, Human Resources should standardize how and what sources of identification are copied for employee records.

#### Why the APA Audits an Agency's Controls Over their Information in the Commonwealth's Retirement Benefits System

The Commonwealth's retirement benefits system is used to calculate total pension liabilities for the Commonwealth. Individual agencies are responsible for updating the records within the retirement benefits system related to their employees. As a result, Social Services' management must take adequate precautions to ensure the integrity of these records. To determine if management implemented these precautions, we compared the practices of Social Services to the guidance provided by Accounts and VRS.

## **Improve Internal Controls for Retirement Benefits System Census Data Reporting**

**Type:** Internal Control

**Severity:** Deficiency

**Repeat:** No

Human Resources does not have sufficient internal controls over the Commonwealth's retirement benefits system census data. Human Resources could not provide supporting documentation to verify that retirement benefits census data was accurate. Our testing focused on terminations, new hires, and salary changes with 13 employees sampled from each area. Specifically, our review found:

- Human Resources was unable to provide a personnel file for one out of the 39 employees requested for testing.
- Six out of 13 employees tested for salary changes could not be verified due to lack of supporting documentation.
- Two out of the 13 terminated employees tested could not be verified due to lack of supporting documentation.

CAPP Manual Topic 50305 - New Employee Adds requires documentation supporting the hiring of employees and subsequent changes must be properly completed and retained for audit purposes. CAPP Manual Topic 50305 also requires agencies to create policies and procedures relating to the entry and review of new hire and change information. This is further communicated in CAPP Manual Topic 50310 - Rehires and Employee Data Maintenance. The VRS Publication Employer Manual - Enroll and Maintain Employees states that all employers are required to provide and maintain accurate data in employee records regarding demographic data, annual salary, contract start date, and period. Accurate census data is required for the retirement benefits system to calculate the employee's creditable compensation.

Due to high turnover in Human Resources, new staff were unable to keep up with the various documentation and filing needs of the agency. Additionally, there were insufficient policies and procedures for new staff to follow regarding Human Resource functions.

Without the most current employee records, Human Resources cannot ensure that the information in the retirement benefits system is correct. Inaccurate data in the retirement benefits system would cause errors in employee's retirement benefits.

Human Resources should establish adequate internal controls to ensure they retain employee files. This should include establishing policies and procedures over this process and ensuring the files are accurate and up to date to comply with the CAPP Manual and VRS employer publications.

## **Improve Reconciliation Process of the Commonwealth's Retirement Benefits System**

**Type:** Internal Control

**Severity:** Deficiency

**Repeat:** No

Social Services Human Resource Department did not adequately perform and document reconciliations between the Commonwealth's retirement benefits system and the Commonwealth's human resource system during fiscal year 2018. We noted that Human Resources did not prepare reconciliations at all during the months of June through September 2018. Although reconciliations were completed for most of fiscal year 2018, the reconciliations we reviewed did not have sufficient documentation, including evidence that the reconciling items were addressed as well as reviewer and preparer signoffs. In addition, there is evidence the reconciliations were not completed prior to confirming the information to VRS. Human Resources does not appear to be following policies and procedures in place to ensure that retirement contribution information has been accurately reported to the Commonwealth's retirement benefits system.

CAPP Manual Topic 50410 requires Human Resources to complete the reconciliation prior to certifying the snapshot confirmation. Guidance from Accounts states that agencies must certify that the Contributions Snapshot from the retirement benefits system is accurate, as this becomes the official basis for VRS's billing amounts once certified. In addition, Accounts instructs agencies to ensure that reconciliations are performed between the retirement benefits and the agency's payroll and human resources systems and all discrepancies are resolved prior to confirmation.

Without devoting the appropriate amount of resources to the reconciliation process and maintaining the appropriate supporting documentation, Human Resources cannot provide assurance that employee records in the retirement benefit and human resource systems are accurate. Inadequate reconciliations can cause errors in members' retirement related data as well as inaccuracies in the Commonwealth's reported pension liability. It can also lead to Social Services under or overpaying retirement contributions to the benefit system, which can create complications when members retire.

Due to high turnover in Human Resources, new staff were unable to keep up with the various documentation needs of the agency. Additionally, it was decided to cease the reconciliations for several months due to lack of resources. Policies and procedures were not being followed for performing reconciliations.

Human Resources should ensure that appropriate resources are devoted to the retirement reconciliation process and should work to improve adherence to processes and procedures to ensure that all reconciliations are performed as required. Human Resources should implement policies and procedures to ensure the completion of reconciliations prior to confirmation of contribution amounts. This will lower the risk of inaccurate information being provided to VRS and ensure the accuracy of reported pension liability amounts.



### Why the APA Audits Journal Entries

Social Services processes over 1,000 journal entries per year to reallocate funds or make other necessary adjustments to the financials. These adjustments collectively have a material impact on the CAFR. We compared Social Services practices to CAPP Manual requirements and best practices.

### **Improve Controls over Journal Entries**

**Type:** Internal Control

**Severity:** Deficiency

**Repeat:** No

Social Services needs to improve controls over journal entries. Eight out of 38 (22%) of the journal entries reviewed did not include adequate documentation to support the nature of the entry. The entries primarily related to realigning expenditures between federal and general funds, but did not include adequate information to justify the reason for the change or how the entry amounts were determined. Additionally, without adequate supporting documentation, it cannot be determined that the entries were coded appropriately.

CAPP Manual Topic 20410 - Intra-Agency Transactions states that substitute forms and procedures by individual agencies are allowed in lieu of Accounts' Journal Entry Form as long as sufficient supporting documentation is maintained. CAPP Manual Topic 20410 also states that the entry approver should review the supporting documentation to ensure the entry contains proper coding for the adjustment. The lack of adequate supporting documentation could create questions as to whether the nature of the transaction is permissible and could lead to potential disallowed charges by the federal government.

Social Services does not have adequate procedures in place that details what type of documentation needs to be retained to support the journal entries. As a result, the reviewers of the entries are not ensuring adequate support for journal entries is being obtained.

Social Services should improve internal controls over journal entries to ensure they include adequate supporting documentation. This would include ensuring that procedures sufficiently detail what supporting documentation is needed and that the review process includes ensuring supporting documentation is adequate.



Martha S. Mavredes, CPA  
Auditor of Public Accounts

# Commonwealth of Virginia

## *Auditor of Public Accounts*

P.O. Box 1295  
Richmond, Virginia 23218

December 14, 2018

The Honorable Ralph S. Northam  
Governor of Virginia

The Honorable Thomas K. Norment, Jr.  
Chairman, Joint Legislative Audit  
and Review Commission

We have audited the financial records and operations of the **Agencies of the Secretary of Health and Human Resources**, as defined in the Audit Scope and Methodology section below, for the year ended June 30, 2018. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### **Audit Objectives**

Our audit's primary objective was to evaluate the accuracy of the Agencies of the Secretary of Health and Human Resources' financial transactions as reported in the Comprehensive Annual Financial Report for the Commonwealth of Virginia for the year ended June 30, 2018, and test compliance for the Single Audit. In support of this objective, we evaluated the accuracy of recorded financial transactions in the Commonwealth's accounting and financial reporting system, in each agency's accounting records, and other financial information reported to the Department of Accounts; reviewed the adequacy of their internal control; tested for compliance with applicable laws, regulations, contracts, and grant agreements; and reviewed corrective actions of audit findings from prior year reports.

### **Audit Scope and Methodology**

Management of the Agencies of the Secretary of Health and Human Resources has responsibility for establishing and maintaining internal control and complying with applicable laws, regulations, contracts, and grant agreements. Internal control is a process designed to provide reasonable, but not absolute, assurance regarding the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws, regulations, contracts, and grant agreements. We gained an understanding of the overall internal controls, both automated and manual, sufficient to plan the audit. We considered materiality and risk in determining the nature and extent of our audit procedures. Our review encompassed controls over the following significant cycles, classes of transactions, and account balances at these four agencies:

*Department of Behavioral Health and Developmental Services*

- Accounts receivable
- Acquisitions and contract management
- Commonwealth's retirement benefit system
- Community Service Board contracts
- Information system security
- Institutional revenues
- Licensing behavioral health providers
- Operational expenses
- Payroll expenses
- Systems access controls

*Department of Health*

- Accounts receivable
- Collection of fees for services
- Cooperative agreements between Health and local government, including:
  - Accounts payable
  - Aid to and reimbursement from local governments
  - Cost allocations
- Federal revenues, expenses, and compliance for:
  - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Information system security
- Inventory
- Payroll expenses
- Rescue squad support
- Systems access controls

*Department of Medical Assistance Services*

- Accounts payable
- Accounts receivable
- Contract management
- Federal revenues, expenses, and compliance for:
  - Medicaid Cluster
- System access controls

*Department of Social Services*

- Accounts payable
- Budgeting and cost allocation
- Child Support Enforcement asset accuracy
- Eligibility for the following programs:
  - Child Care and Development Fund
  - Low Income Heating and Energy Assistance

- Medicaid
- Temporary Assistance for Needy Families
- Federal revenues, expenses, and compliance for:
  - Low Income Heating and Energy Assistance
  - Supplemental Nutrition Assistance Program Cluster
  - Temporary Assistance for Needy Families
- Network and system security
- Subrecipient monitoring
- Supplemental Nutrition Assistance Program supplemental information
- Systems access controls

The following agencies under the control of the Secretary of Health and Human Resources are not material to the Comprehensive Annual Financial Report for the Commonwealth of Virginia. As a result, these agencies are not included in the scope of this audit.

- Department for Aging and Rehabilitative Services
- Department for the Blind and Vision Impaired
- Department for the Deaf and Hard-of-Hearing
- Department of Health Professions
- Office of Children's Services
- Virginia Board for People with Disabilities
- Virginia Foundation for Healthy Youth
- Virginia Rehabilitation Center for the Blind and Vision Impaired
- Wilson Workforce and Rehabilitation Center

We performed audit tests to determine whether the agencies' controls were adequate, had been placed in operation, and were being followed. Our audit also included tests of compliance with provisions of applicable laws, regulations, contracts, and grant agreements. Our audit procedures included inquiries of appropriate personnel; re-performance of automated processes; inspection of documents, records, and contracts; and observation of the agencies' operations. We performed analytical procedures, including budgetary and trend analyses. Where applicable, we compared an agency's policies to best practices and the Commonwealth's Information Security Standard. We also tested details of transactions to achieve our objectives.

A nonstatistical sampling approach was used. Our samples were designed to support conclusions about our audit objectives. An appropriate sampling methodology was used to ensure the samples selected were representative of the population and provided sufficient, appropriate evidence. We identified specific attributes for testing each of the samples and when appropriate, we projected our results to the population.

## **Conclusions**

We found that after adjustments, Medical Assistance Services properly stated, in all material respects, the amounts recorded and reported in the Commonwealth's accounting and financial reporting system, in the agency's accounting records, and in other financial information reported to the Department of Accounts for inclusion in the Commonwealth's Comprehensive Annual Financial Report.

We found that the remaining Agencies of the Secretary of Health and Human Resources, as defined in the Audit Scope and Methodology section above, properly stated, in all material respects, the amounts recorded and reported in the Commonwealth's accounting and financial reporting system, in each agency's accounting records, and in other financial information reported to the Department of Accounts for inclusion in the Commonwealth's Comprehensive Annual Financial Report.

Our consideration of internal control was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies; and therefore, material weaknesses and significant deficiencies may exist that were not identified. However, as described in the section titled "Internal Control and Compliance Findings and Recommendations," we identified deficiencies in internal control that we consider to be material weaknesses and other deficiencies that we consider to be significant deficiencies in internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial information or material non-compliance with provisions of a major federal program will not be prevented or detected and corrected on a timely basis. We have explicitly identified two findings in the section titled "Internal Control and Compliance Findings and Recommendations" that we consider to be material weaknesses for the Commonwealth.

A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We have explicitly identified forty-one findings in the section titled "Internal Control and Compliance Findings and Recommendations" as significant deficiencies for the Commonwealth.

As the findings noted above have been identified as material weaknesses or significant deficiencies for the Commonwealth, they will be reported as such in the "Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards," included in the Statewide Single Audit Report for the year ended June 30, 2018. Certain findings relate to federal programs; as such, these findings will be reported in the "Independent Auditor's Report on Compliance for Each Major Federal Program; Report on Internal Control over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by Uniform Guidance," which is also included in the Single Audit Report for the year ended June 30, 2018. The Single Audit will be available on APA's website at [www.apa.virginia.gov](http://www.apa.virginia.gov) in February 2019.

In addition to the material weaknesses and significant deficiencies, we detected deficiencies in internal control that are not significant to the Commonwealth's Comprehensive Annual Financial Report and Single Audit, but are of sufficient importance to warrant the attention of those charged with governance. We have explicitly identified five findings in the section titled "Internal Control and Compliance Findings and Recommendations" as deficiencies.

The Agencies of the Secretary of Health and Human Resources have taken adequate corrective action with respect to audit findings reported in the prior year that are not referenced as “repeat” findings in the section titled “Internal Control and Compliance Findings and Recommendations.”

**Exit Conference and Report Distribution**

We discussed this report with management for the agencies included in our audit as we completed our work on each agency. Management’s responses to the findings identified in our audit is included in the section titled “Agency Responses.” We did not audit management’s responses and, accordingly, we express no opinion on it.

This report is intended for the information and use of the Governor and General Assembly, management, and the citizens of the Commonwealth of Virginia and is a public record.

AUDITOR OF PUBLIC ACCOUNTS

LCW/clj




S. HUGHES METON, MD, MBA,  
FAAFP, FABAM  
COMMISSIONER

**COMMONWEALTH of VIRGINIA**  
**DEPARTMENT OF**  
**BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**  
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Richmond, Virginia 23218-1797

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**MEMORANDUM**

**TO:** Martha Mavredes, CPA  
Auditor of Public Accounts

**FROM:** S. Hughes Melton, MD, MBA, FAAFP, FABAM 

**SUBJECT:** Responses to FY 2018 HHR Report

**DATE:** January 7, 2019

The purpose of this memo is to provide the Department of Behavioral Health and Developmental Services (DBHDS) responses to the audit findings listed in the HHR report. We concur with the findings, and our response and brief summary of planned corrective actions for each finding are included below:

**Improve Controls over Financial Reporting:**

DBHDS concurs with the finding. The finding notes that the estimation process is reasonable, and we plan to maintain the same basic process during the FY 2019 year-end close and financial reporting cycle. The distinction between fixed and term contracts will be identified much more clearly by the Office of Procurement and Contracting in order to enable a truer calculation of the commitment estimate in FY 2019. Regarding the commitments associated with capital outlay, this process is currently being refined as we implement the new AIM architectural and engineering software.

**Improve IT Contingency Management Program (Repeat):**

DBHDS concurs with the finding. DBHDS is changing the infrastructure to a more cloud based architecture which will provide greater availability of resources. This change is based on approved cloud based funding. Continuity of Operations Plans and Disaster Recovery Plans are changing to support the new infrastructure and will be completed by October 1, 2019.



**Continue to Upgrade Unsupported Technology (Repeat):**

DBHDS concurs with the finding. DBHDS is finalizing the implementation of supported technology, and this will be completed by May 1, 2019.

**Develop Baseline Configurations for Information Systems (Repeat):**

DBHDS concurs with the finding. DBHDS has baseline configurations for hardware, and we are completing the baseline configurations for software requirements. This will be completed by October 1, 2019.

**Improve Web Application Security:**

DBHDS concurs with the finding. DBHDS will immediately move the central administrator to a team of existing application support administrators to provide better support and continuity of operations through cross training. Additional action plans will be developed and implemented by July 1, 2019.

**Improve Access Controls over the Internal Accounting System:**

DBHDS concurs with the finding. DBHDS will improve access controls by Oct 1, 2019. This will include continuing to conduct security monitoring activities at all regions and facilities and ensuring they are sufficiently documented.

**Develop and Implement Compliant Application Access Management Procedures:**

DBHDS concurs with the finding. DBHDS will work with its facilities to ensure their procedures match the Agency's existing Policy. This will be completed by July 1, 2019.

**Improve Internal Controls over Capital Assets:**

DBHDS concurs with the finding. DBHDS has already contacted the Department of Accounts (DOA) to have them remove all assets related to the Northern Virginia Training Center from the Cardinal and FAACS systems. Once DOA removes the assets, the concerns in the comment will have been addressed.

**Improve Controls over the Purchasing Process:**

DBHDS concurs with the finding. The Fiscal Director at the applicable DBHDS facility will review the relevant CAPP Manual policies and procedures for the receipt of goods and services with applicable Accounts Payable personnel and backups. Expenditure voucher samples will be pulled once a month for the period January through June 2019 to monitor compliance with CAPP Manual regulations. Expenditure audits will also be conducted during the FY 2019 ARMICS Internal Controls Review and Testwork.

In August 2018, Fiscal and Procurement staff at the facility discovered the exception noted and "self- corrected" to comply with a new procurement regulation issued under Procurement Information Memoranda 98-034 dated 7/1/17. Prior to the corrective action, the facility was not compliant with Memoranda 98-034 because Fiscal Staff were not forwarding purchase orders for



eVA exempt vendors for medical services and prescription drugs to Procurement personnel to enter into eVA. To ensure future compliance, Fiscal personnel will meet with Procurement personnel to review the requirements of Memoranda 98-34 and any subsequent updates. Medical Services and prescription drug expenditure samples will be pulled once a month for the period January through June 2019 to monitor compliance. Medical Services and Prescription Drug purchases will also be reviewed during the FY 2019 ARMICS Internal Controls Review and Testwork.

The estimated completion date to fully implement the corrective actions noted above is June 30, 2019.

**Improve Controls over the Commonwealth's Retirement Benefits System (Repeat):**

DBHDS concurs with the finding. All facilities have the identical policy; however, it is not always being followed properly. DBHDS will work with its facilities to ensure all employees are trained on the procedures. This will be completed by July 1, 2019.

**Comply with Employment Eligibility Requirements:**

DBHDS concurs with the finding. DBHDS will ensure all facility Human Resources staff are trained on employment eligibility requirements, on how to fill out the I9, and on how to use E-verify. It should be noted that training was offered to staff in December 2018. Corrective actions will be completed by March 1, 2019.

**Improve Controls over Payroll (Repeat):**

DBHDS concurs with the finding. The DBHDS Office of Internal Audit conducted this particular payroll testwork and reviewed management responses to the findings that were provided by the various facilities tested. The Office of Internal Audit will conduct follow-up reviews by September of 2019 to ensure that adequate corrective actions were implemented for the following: (1) findings from the FY 2018 payroll reviews; and (2) repeat findings from the FY 2018 payroll follow-up reviews performed on the (prior year's) FY 2017 findings.

**Comply with 1,508 Hour Rule for Wage Employees:**

DBHDS concurs with the finding. DBHDS will ensure all of its facility Human Resources offices track the 1,508 hour rule for wage employees. This has already been corrected at the facilities involved with the finding, and information will be sent to Human Resources staff at all facilities with reminders of the rule and how to track wage hours. This will be completed by March 1, 2019.

**Improve Controls Surrounding At-Will Employees:**

DBHDS concurs with the finding. DBHDS will ensure that certification letters are in the leave file for each at-will employee. This will be completed each year going forward based on the leave calendar.

Please let me know if you have any questions about the information we have provided.

cc: Mira Signer, DBHDS Chief Deputy Commissioner for Community Behavioral Health Services  
Alexis Aplasca, MD, DBHDS Chief Clinical Officer  
Connie Cochran, DBHDS Acting Deputy Commissioner for Administrative Services  
Heidi Dix, DBHDS Acting Deputy Commissioner for Compliance, Legislative & Regulatory Affairs  
Daniel Herr, DBHDS Deputy Commissioner for Facility Services  
Heather Norton, DBHDS Acting Deputy Commissioner for Developmental Services  
Dev Nair, DBHDS Assistant Commissioner for Licensing and Compliance  
Michael Schaefer, DBHDS Assistant Commissioner for Forensic Services  
Andrew Diefenthaler, DBHDS Deputy Director for Finance and Administration  
Ken Gunn, DBHDS Director of Budget Execution and Financial Reporting  
Dan Hinderliter, DBHDS Director of Procurement and Administrative Services  
John Moore, DBHDS Director of Fiscal and Grants Management  
Stacy Pendleton, DBHDS Co-Director of Human Resources Development and Management  
Sue Ridout, DBHDS Co-Director of Human Resources Development and Management  
Chris Sarandos, DBHDS Chief Information Officer  
Florence Wells, DBHDS Director of Cost Accounting and Reimbursement  
Greg Bell, DBHDS Chief Information Security Officer  
Amy Smiley, NVMHI Hospital Director  
John Poffenbargar, NVMHI Fiscal Officer  
Kathy Brown, DBHDS Acting Internal Audit Director



# COMMONWEALTH of VIRGINIA

## Department of Health

M. Norman Oliver, MD, MA  
State Health Commissioner

P O Box 2448  
RICHMOND, VA 23218

TTY 7-1-1 OR  
1-800-828-1120

December 20, 2018

Martha S. Mavredes, CPA  
Auditor of Public Accounts  
P.O. Box 1295  
Richmond, VA 23218

Dear Ms. Mavredes:

We have reviewed your report on our audit for the year ended June 30, 2018. We concur with the findings and our corrective action plan has been provided separately.

We appreciate your team's efforts and constructive feedback. Please contact Alvie Edwards, Internal Audit Director, if you have any questions regarding our corrective action plan.

Sincerely,

A handwritten signature in blue ink that reads "M. Norman Oliver MD".

M. Norman Oliver, MD, MA  
State Health Commissioner



# COMMONWEALTH of VIRGINIA

## *Department of Medical Assistance Services*

JENNIFER S. LEE, M.D.  
DIRECTOR

SUITE 1300  
600 EAST BROAD STREET  
RICHMOND, VA 23219  
804/786-7933  
800/343-0634 (TDD)  
[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

January 17, 2019

Ms. Martha S. Mavredes  
The Auditor of Public Accounts  
P. O. Box 1295  
Richmond, Virginia 23218

Dear Ms. Mavredes:

We have reviewed the draft Management Report for the Department of Medical Assistance Services (DMAS) that will be included in the report for the Audit of the Agencies of the Secretary of Health and Human Resources for the Fiscal Year Ending June 30, 2018. We concur with the audit findings assigned to DMAS. We will send a response to the Department of Accounts, within the required thirty days after the report is issued. The response will include the workplan for corrective actions to be taken to address the audit findings.

If you have any questions or require additional information, please do not hesitate to contact the DMAS Internal Audit Director, Susan Smith.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Lee, M.D." with a stylized flourish at the end.

Jennifer Lee, M.D.  
DMAS Director



**Department of Medical Assistance Services**  
**APA Audit of the DMAS for the Fiscal Year Ending June 30, 2018**  
**Corrective Action Plan**  
**January 17, 2019**

**Strengthen Controls over Year-End Reporting (issued as MP#7)**

*Condition*

Medical Assistance Services needs to strengthen controls over year-end accrual reporting information submitted to Accounts. Medical Assistance Services' accrued claims calculation contained several errors that resulted in a material misstatement of the accrued claims payable and related federal receivable reported to Accounts for inclusion in the Commonwealth's financial statements. Specifically, the following errors were found:

- Staff incorrectly entered data into a spreadsheet resulting in a \$3.7 million understatement of the total claims payable liability. This error also impacted federal expenditures, general fund expenditures, federal receivables, and federal revenue.
- Staff incorrectly included prior year amounts in the pharmacy rebate forecast resulting in a \$6.1 million overstatement of the total claims payable liability. This error also impacted federal expenditures, general fund expenditures, federal receivables, and federal revenue.
- The Budget Division revised its accrual methodology and did not inform the Fiscal Division which resulted in a \$17.8 million understatement of the federal claims payable liability and a \$17.8 million overstatement of the general fund claims payable liability. This error also impacted federal expenditures, general fund expenditures, federal receivables, and federal revenue.
- Staff incorrectly entered data into a spreadsheet resulting in a \$1.4 million overstatement of the general fund claims payable liability. This error also impacted general fund expenditures.

*Recommendation*

Policies and procedures over financial reporting information, as a best practice, should be detailed and thorough with a sufficient review process to prevent and detect potential errors or omissions. Also as a best practice, the Fiscal and Budget Divisions should collaborate to complete the year-end accrual information reported to Accounts for inclusion in the Commonwealth's financial statements.

Medical Assistance Services should review and strengthen their policies and procedures over the preparation of year-end financial reporting information for Accounts. These procedures should include a supervisory review to help detect and prevent errors and, ideally, eliminate the need for multiple revisions. As part of this process, the Budget Division and the Fiscal Division should collaborate as needed to ensure there is a common understanding of significant financial reporting policies and that submitted information is accurate. Given the significance of Medical Assistance Services' financial

**Department of Medical Assistance Services**  
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activity, it is also important that they consult with Accounts on financial reporting issues that may be complex or unusual to ensure both agencies have a thorough understanding of the nature of the activity and agree on the correct financial reporting treatment.

**Corrective Action Plan:**

In the time leading up to year-end financial reporting, DMAS experienced a loss of knowledgeable Fiscal staff. This resulted in the remaining skeletal staff completing both Federal and State reporting at the same time. Additionally, the Budget Division has been understaffed for several months. As a result, DMAS intends to increase staffing in the Fiscal and Budget Divisions to appropriate levels to allow for more extensive reviews of year-end reporting prior to submission.

DMAS has already taken actions to improve staffing levels in the Fiscal Division. DMAS executive leadership has appointed an acting Fiscal Division Director. At the time of year-end reporting, the Fiscal Division Director was on extended leave, and an acting Division Director had not been appointed yet. Additionally, DMAS has created a new position in the Fiscal Division, the Fiscal Senior Advisor, to act as a back-up to the Division Director. These personnel actions will ensure that staff is available to conduct an executive level review on year-end submissions.

In addition, DMAS has hired an outside consultant to complete federal reporting work until new staff for the Federal Reporting Unit can be recruited. The outside consultant will also provide training to the new federal reporting staff. These actions will ensure that General Ledger and State Reporting staff are not also tasked with federal reporting.

The Budget and Fiscal Divisions will meet in early August 2019 to discuss and document the approach they are taking to estimating accruals. This early level-setting meeting will allow the divisions to mutually set a schedule and approach to accrual estimation and avoid a time-crunch in early September that can lead to errors.

The Budget Division documents a review of the accruals prior to submission to the Fiscal Division. The Fiscal Division will document an executive level review of year-end accrual reporting prior to submission of year-end reporting to the Department of Accounts.

**Responsible Person(s):**

- Lanette Walker, DMAS Budget Director, Budget Division
- Tanyea Darrisaw, DMAS Acting Fiscal Director, Fiscal Division

**Estimated Implementation Date:** September 30, 2019

**Department of Medical Assistance Services**  
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**Corrective Action Plan**  
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**Remove Access to the Current Claims Processing System in a Timely Manner**  
**(issued as MP#1)**

*Condition*

Medical Assistance Services did not remove access to the claims processing system timely for individuals who no longer needed access. Specifically, six of eight employees tested did not have their system access disabled within 24 business hours of separation. Additionally, we identified three other employees whose access was not removed within 24 business hours. The nine employees in question retained their system access between three and 72 days after separation.

*Recommendation*

Compliance and Security and the Human Resources Division should establish effective, regular communication to report staff changes to those individuals responsible for managing system access. In addition, Compliance and Security should ensure compliance with its Access Control Policy and the Security Standard by removing users' access as required.

**Corrective Action Plan:**

Office of Compliance and Security (OCS):

- OCS Access management team set up a new tracking, review and suspend process in December 2018 to ensure timely removal of access to the Claims Processing System.
- OCS is working with Human Resources Division and managers and supervisors to have management directly notify OCS of exiting employees.

Human Resources Division (HR)

- HR notifies OCS of employee terminations through the following standing operating procedures/processes:
  - HR emails a weekly HR Infoshare – Staff Changes notification to all DMAS employees which includes OCS staff. This includes all employee terminations/separations.
  - For immediate discharges/terminations, the HR director or HR Benefits and Operations Manager emails OCS directly an “Advance Notice” email to alert OCS immediately that access needs to be terminated.
  - HR’s off-boarding process requires managers and supervisors of exiting employees to initiate the Exit Clearance Form. All relevant divisions have to sign off on the form as applicable including OCS.



**Department of Medical Assistance Services**  
**APA Audit of the DMAS for the Fiscal Year Ending June 30, 2018**  
**Corrective Action Plan**  
**January 17, 2019**

- HR and the Information Management Division have worked together to complete the Exit Clearance Automation workflow process in K2. This process was launched on January 11, 2019. Instructions and a training video were sent to all DMAS workforce members on January 11, 2019. This will automate the exit clearance process which was previously a manual process. The exit notice will flow to OCS and HR.
- At the Management Team meeting on January 14, 2019, all division managers and the Executive Management Team were notified that the Exit Clearance workflow process was implemented and that all of their managers and supervisors are required to initiate a separating employee's exit clearance through the share point application.

**Responsible Person(s):**

- Mukundan Srinivasan, DMAS Chief Information Security Officer, Information Management Division
- Bill Burnette, DMAS Information Security Officer, Office of Compliance and Security

**Estimated Implementation Date:** January 31, 2019

**Continue Improving the Accounts Receivable Collection Process (issued as MP#8)**

*Condition*

Medical Assistance Services' Fiscal Division needs to continue to improve their collection process for overpayments. Although improvements have been made in this area since our last audit, we found the following instances where the Fiscal Division did not follow policies and procedures for collecting overpayments identified by the various Program Integrity reviews.

- For two of seven (29 percent) overpayments identified by the Provider Review Unit, the invoicing letter was not sent to the provider in a timely manner.
- For 13 overpayments identified by the Recipient Audit Unit, nine (69 percent) final letters were not sent in a timely manner, and one final letter was not mailed at all. In addition, six of these cases were referred to collections several months late.
- For one of five (20 percent) overpayments identified by the Utilization Review Unit, the invoicing letter was not sent to the provider in a timely manner.



**Department of Medical Assistance Services**  
**APA Audit of the DMAS for the Fiscal Year Ending June 30, 2018**  
**Corrective Action Plan**  
**January 17, 2019**

*Recommendation*

According to management, the Accounts Receivable Unit has been understaffed for several years, which has caused a backlog in this area. Fiscal year 2018 has been a transitional period for the Accounts Receivable Unit as they have focused on clearing the backlog of collections and streamlining operations. Significant improvements have been made, but some issues remain. Additionally, the implementation of an automated overpayment processing function has been delayed due to a shift in agency priorities, and this has impacted the Unit's ability to completely resolve these issues. Medical Assistance Services should continue to strengthen collection processes and ensure they are performed timely and in accordance with policies and procedures.

**Corrective Action Plan:**

The untimely processing of accounts receivable transactions is directly associated with the use of manual processes to set up accounts receivable transactions. The volume of cases received in the Accounts Receivable (AR) area are greater than what current staffing levels in that area are able to handle manually. The Fiscal Division has taken action to increase staffing levels in the AR unit, and will soon be implementing a new system that will allow for automation of some components of the AR process, that will decrease the amount of time required for each AR transaction.

Workflow Process Improvement:

The Program Integrity Division partnered with the Information Management Division to leverage the new claims payment systems to meet their needs with case management and analytics. Program Integrity is introducing a new system that will serve as an analytical tool to manage cases. After the new system goes live, Fiscal will partner with Program Integrity to determine system enhancements that will allow for an interface between the new system and the AR system which will further automate the member receivable process. In the meantime, Fiscal has increased staffing with temporary resources to assist with member receivables.

Provider Receivables:

Fiscal continues to work on improving collections for provider receivables. Fiscal added two additional resources in provider receivables in the past 12 months.

Member Receivables:

Fiscal added an additional resource for the member (recipient) receivable collections and now have three resources working in this area. This area is still a very manual process until Program Integrity's system goes live. We are going to review methods that will

**Department of Medical Assistance Services**  
**APA Audit of the DMAS for the Fiscal Year Ending June 30, 2018**  
**Corrective Action Plan**  
**January 17, 2019**

efficiently track the receivables manually until then. Ultimately, the new system will interface with the AR system and help reduce the manual tasks.

**Responsible Person(s):**

- Tanyea Darrisaw, DMAS Acting Fiscal Director, Fiscal Division

**Estimated Implementation Date:** December 31, 2019

**Ensure Employees Complete Required Conflict of Interest Training (issued as MP#4)**

*Condition*

Medical Assistance Services did not ensure employees completed the required Conflict of Interest orientation course within the timeframe outlined in the Code of Virginia. Specifically, 18 out of 128 (14 percent) employees who hold positions of trust did not complete the Conflict of Interest orientation course.

*Recommendation*

The Human Resources Division should ensure compliance with its internal policy and the Code of Virginia by monitoring all employees designated in a position of trust to ensure they complete the required Conflict of Interest orientation course within two months of becoming a filer and once within each consecutive period of two calendar years thereafter. The Human Resources Division should also maintain a record of such attendance.

**Corrective Action Plan:**

The Human Resources Division (HR) includes a reference to completion of an annual Statement of Economic Interests (SOEI) on all job postings for positions of trust. HR has also added a reference on the job postings about the required Conflict of Interest Act (COI) Training. In addition, employment offer letters state that employees in positions of trust must complete a SOEI at hire and annually thereafter. HR has also added information in employment offer letters about the COI training requirement and their responsibilities.

Before new hires who will hold positions of trust start employment, HR sends an email to their personal email addresses (because the new hire does not yet have a Commonwealth of Virginia Account) to inform them that they have to complete the SOEI on or before the date of employment. HR includes information in the email about the required COI training and that they will have to complete the training within the first two months of employment. HR will follow-up on all new employees designated in

**Department of Medical Assistance Services**  
**APA Audit of the DMAS for the Fiscal Year Ending June 30, 2018**  
**Corrective Action Plan**  
**January 17, 2019**

positions of trust to ensure they complete the required COI training within two months of hire to ensure that they complete the training.

HR has continued to work with the Ethics Council Coordinator regarding issues with the database and managing DMAS' information on positions of trust. HR also works with the Ethics Council Coordinator to answer questions that DMAS filers may have when they are completing a SOEI.

In December 2018, HR performed the annual update to the Disclosure System and verified that the DMAS employees, associated positions, and contact information was correct in the system. On January 7, 2019, HR emailed all filers with notice that they are responsible for taking the COI training every two years.

It is an extremely manual process to track the COI training because the COI training on the Virginia Learning Center (VLC) does not interface with the Ethics Council's Disclosure System. The systems also do not notify filers when training has not been completed. The VLC report only reflects those who took the training not those who did not take the training.

HR will verify completion of the COI training by running training reports from the VLC. On a monthly basis, HR will develop a method to cross check the training report to a report from the Commonwealth of Virginia's personnel database. This is the official system of record where state agencies designate which positions are considered positions of trust and which incumbents are required to file the SOEI and complete the COI training. HR will use this reconciliation process to follow-up with filers to ensure training is completed.

**Responsible Person(s):**

- Kathleen Guinan, DMAS Human Resources Director, Human Resources Division

**Estimated Implementation Dates:** March 31, 2019



# COMMONWEALTH of VIRGINIA

## DEPARTMENT OF SOCIAL SERVICES

*Office of the Commissioner*

S. Duke Storen  
COMMISSIONER

January 22, 2019

M. Martha Mavredes  
Auditor of Public Accounts  
101 North 14<sup>th</sup> Street  
Richmond, VA 23219

Dear Ms. Mavredes:

The Virginia Department of Social Services concurs with the audit findings included in the 2018 review by the Auditor of Public Accounts.

Should you require additional information, please do not hesitate to contact Michael L. Gump, Chief Financial Officer, by email at [michael.gump@dss.virginia.gov](mailto:michael.gump@dss.virginia.gov) or by telephone at (804) 726-7223.

Sincerely,

A handwritten signature in dark ink, appearing to read "S. Duke Storen".

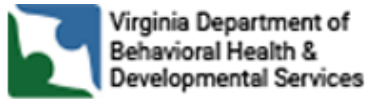
S. Duke Storen



## AGENCIES OF THE SECRETARY OF HEATH AND HUMAN RESOURCES

As of June 30, 2018

Daniel Carey, M.D., Secretary of Health and Human Resources



### Department of Behavioral Health and Developmental Services

S. Hughes Melton, M.D., MBA, FAAFP, FABAM – Commissioner



### Department of Health

M. Norman Oliver, M.D., MA – Commissioner



### Department of Medical Assistance Services

Jennifer S. Lee, M.D. – Director



### VIRGINIA DEPARTMENT OF SOCIAL SERVICES

### Department of Social Services

S. Duke Storen – Commissioner